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ABSTRACT

A two-year (1977-1979) program was developed to increase mental health services to students and their families in an inner city school. The counseling supervisor from the school district and the director of a mental health agency developed a mobile mental health program. Students and their families were not always able to go to the agency for needed services, therefore, the agency was brought to them. This practicum describes a two-year effort by which the counseling supervisor implemented the program at a pilot site, the Lehigh Elementary School. During the second year, it was expanded to four additional schools in the district providing needed mental health services to students and their families. (Author)

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A MOBILE PROGRAM TO PROVIDE MENTAL-HEALTH SERVICES TO STUDENTS OF AN INNER-CITY SCHOOL AND THEIR FAMILIES

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Individual Practicum
Presented to
The Faculty of the Graduate School
Nova University

In Partial Fulfillment of the Requirements
for the Degree
Doctor of Education

by

Agnes W. Barksdale
Philadelphia II
May 1979

CG 014396

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STATEMENT OF PROBLEM

Families

In recent years a deterioration of the American family in general has been noted. The impact has certainly affected cities across the nation including Philadelphia.

Walter Mondale, the Vice President of the United States, reported in the May 1977 issue of Psychology Today that families are enduring institutions. They have been the foundation for every society known to history. They are characterized as having incredible strength and resiliency. However, he further indicates in his article, "The Family in Trouble," that too many families are experiencing increasing stresses and pressures. He cites the following symptoms: [22]

- Juvenile crime on the rise.
- The rate of illegitimacy has more than doubled in the past three decades.
- Suicide is a leading cause of death among young people.
- At least 200,000 children are physically abused by their parents or guardians every year.

As a society, Mr. Mondale indicates that we have given too little attention to the needs of families.

In the May 15, 1978 issue of Newsweek in a special report entitled, "Saving the Family," the strengths and weaknesses of the American family are highlighted. The strengths indicate the following: [28]

- 98 percent of all American children are raised in families.
- In 1977, 78 percent of these children were living with two parents.
- Nearly 2/3 of all couples remain married until death.
- The divorce rate seems to be leveling off and of those parents who divorce, 75 percent of the women, and 83 percent of the men remarry within three years.
- Only a fraction of 1 percent of Americans admitted to cohabitation according to a 1977 census report and most of them will eventually marry.
- More and more we are seeing a new commitment to child rearing and family control no matter what sort of family structure evolves.

The evidence pointing to deterioration, according to the Newsweek article [28] indicates:

- The Marriage odds--of all United States adults
  96 percent will marry
  38 percent of those will divorce
  79 percent of those will remarry
  44 percent of those will divorce again.
- As many as 4 children out of 10 born in the 1970s will spend part of their childhood in a single-parent

family, usually with the mother as head of the household.

- Remarriage currently blends about 18 million stepchildren from the remnants of what used to be called "broken," families into new family units.
- What was defined as "deviant" a decade ago is now called "variant" and therefore lends a healthy experimental quality to current social exploration beyond monogamy of the nuclear family.
- At least 15 percent of all births are illegitimate and more than half of all children born out of wedlock are born to teenagers with a particularly high rate among Blacks.
- Of the 513,000 children born to black women in 1976, 50.3 percent were illegitimate. It is the illegitimate, both black and white that are most likely to be impoverished, dependent on welfare, deprived of educational opportunities and destined to repeat the cycle with illegitimate children of their own.

North Philadelphia, which is the section of Philadelphia discussed in this practicum characterizes the above description. The majority of the residents are also black. The May 15, 1978 issue of Newsweek [28] gives the following data on Blacks:

- In 1965 Daniel Patrick Moynihan, then Assistant Secretary of Labor, concluded in a Labor Department report that "at the heart of the deterioration of the fabric of Negro society is the deterioration of the Negro family."

- By the Moynihan measurement today, most black families are even worse off than they were then. Although there are notable gains in the number of middle-class black families, the reality is more black families are headed by women with an increase from 24 percent at that time to 36 percent in 1977.
- More black children are born out of wedlock, more often to girls in their teens.
- More black heads of households are without jobs. The unemployment rate for Blacks climbed from 8 percent in 1965 to 13 percent in 1977.
- In 1961, 14 percent of black children were receiving Federal Aid to Families with Dependent Children; in 1976, 38 percent received A.F.D.C.

Philadelphia is a large urban city with various problems and needs. The frustrations and anxieties experienced by families living in the inner-city ghettos are often reflected in the behavior and academic performance of students in the schools. As stable neighborhoods in North Philadelphia changed to ghetto areas, standardized test scores for students in the schools steadily declined. Teachers constantly indicated that they were beset with discipline problems.

Community Mental Health Agencies

Certainly these facts indicate the need for additional help and support in ghetto areas as they try to cope with the daily stresses of living. Community mental health agencies are available throughout the city of Philadelphia for help. However, most of them are under utilized. In North Philadelphia, personnel from the mental health agencies that serve the neighborhoods constantly come to the schools offering their assistance and indicating a lack of clients from the community.

Counselors working in the schools often make referrals to these agencies but very few families follow through for help. Quite often parents are not ready to go out of the immediate neighborhood for help, and the school counselor provides support until they can take that step.

However, there are many parents who do see the need, they desire help but for varied reasons they do not get to the centers. Some parents indicate that they work during the day and are too tired to go out in the evening. Others openly admit a fear or hesitance to go to a "strange" agency. School staffs constantly complain to counselors of their frustration in the classroom with students who need help and yet whose parents will not seek outside help.

Exploratory work was done by the counseling supervisor for one of the districts in the Philadelphia School System to provide a more accessible way of providing mental health services to students and their families. She conferred with counselors and visited the local mental health/mental retardation agency to discuss the problem.

The supervisor of counseling and the director of Family and Children Services for North Central Mental Health Agency conceived the idea of bringing the services of the agency to the school as a possible solution in meeting the needs of more students and their families. The director received federal funding to purchase a van and to convert it into a mobile unit to provide service. The supervisor of Counseling Service introduced the idea to the district superintendent and to the principals. The response was enthusiastic.

After consultation with the district superintendent and the director of North Central Mental Health/Mental Retardation Agency, Dr. Averette Parker, one elementary school was chosen as the pilot site. The school chosen was Lehigh. This school serves children in the North Philadelphia area from grades K to 5.

Before the pilot program could begin, a financial crisis occurred in the Philadelphia Public School System. This necessitated the layoff of all personnel working in non-mandated areas. Counseling was one of the areas;

therefore, the counseling supervisors, and all counselors received layoff notices.

Within two months the state legislature approved additional funding for the Philadelphia schools and the local banks provided the school system with a 50 million dollar loan. This additional funding enabled the restoration of counseling and other services.

The counseling supervisor attempted to contact the director of North Central MH/MR to continue the possibility of a mobile mental health program and was informed that she had resigned to take a new job in another state. The van had been purchased; however, nothing could be done until a new director was appointed.

Within a month, Dr. Robert Clark was assigned as the new director of Children and Family at North Central MH/MR Agency and indicated that he was willing for the mobile program to be resumed. The supervisor of counseling along with the assistant director of Family and Childrens Services for North Central MH/MR approached the principal of the Lehigh School to begin the program at his school in spite of our previous setbacks. He was still receptive, and Lehigh Elementary School became our pilot site.

Lehigh School

The Lehigh School is located on Lehigh Avenue in North Philadelphia and hence its name. It is located in the heart of the Black ghetto area. Unemployment is high and so is the crime rate. The building is a relatively new one-story modern structure. Grafitti decorates the exterior of the building, however, it is attractive and clean inside.

The principal is quite dedicated and very enthusiastic. He has completed three years at this school which is his first assignment as a principal. He is well liked by staff, students and parents. There is one counselor. She is experienced in all areas of counseling and recently transferred to the Lehigh School because of staff cuts in her previous school. She is efficient and is also well liked. There are 52 teachers and paraprofessionals.

Student Population

There are 740 students, and 35 are in special ecuation classes.

As you enter the school you see the Educational Philosophy of Lehigh School. It is as follows:

- We Believe That Every Student is Capable of Learning as Much as They Want To.
- We Believe That Every Student Is Important.
- We Believe That Every Student Should Be Respected By All Adults and Their Schoolmates.
- We Believe That Each Pupil Should Be Instructed at Their Own Level of Achievement.
- We Believe That Each Pupil Should Be Encouraged To

Do Their Best At All Times By Teachers, Parents, and Friends.

- We Believe That Every Student Has the Right To Be Happy While Learning At Lehigh.

North Central Philadelphia Mental Health/ Mental Health Retardation Agency

North Central MH/MR Agency is the community mental health agency that serves the students and their families attending the Lehigh School. Salient data on this agency follows.

North Central Philadelphia CMH/MR Center

Catchment Area #5A

I. Children and Family Unit
Director: Robert R. Clark, M.D.
3701 N. Broad St.
Phila., Pa. 19140
(215) 226-5000, Ext. 340

Ages Served: Children from ages 1 to 16 and their families and mentally retarded persons of all ages.

Service Location: Children's services, including intake procedures are centralized at 3701 N. Broad St. Take elevator to 2nd floor and turn right.

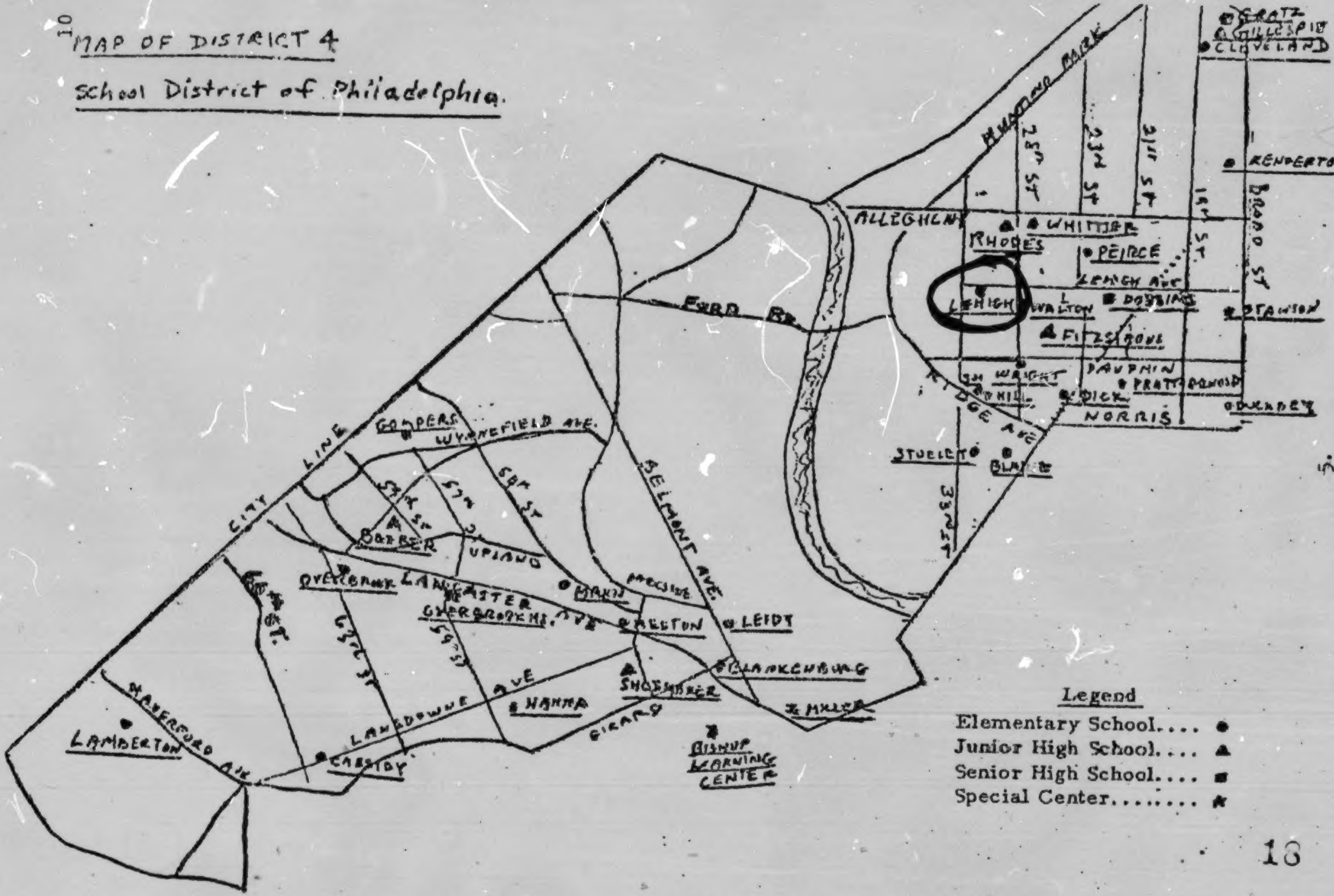
Telephone Number: 226-5000 Ext. 340 for all calls, including intake.

Hours: Monday thru Friday, 9-5. Emergency services at the Crisis Center, 24 hours a day, 7 days a week.

Fee Scale: Fees for services are based on a sliding scale, depending upon the

MAP OF DISTRICT 4

School District of Philadelphia


HUNTING PARK
25TH ST
23RD ST
21ST ST
18TH ST
BROAD ST
GRATZ
GILLESPIE
CLEVELAND
KENDERTON
ALLEGHENY
WHITTIER
RHODES
PEIRCE
LEHIGH AVE
LEHIGH
WALTON
DOBBINS
STANTON
FITZSIMONS
DAUPHIN
WRIGHT
HILL
DICK
PRATT
NORRIS
RIDGE AVE
STOECKER
BLAINE
33RD ST
FORD RD.
CITY LINE
GOMPERS
WYNNEFIELD AVE.
54TH ST
52ND ST
58TH ST
BARBER
UPLAND
BELMONT AVE.
OVERBROOK
LANCASTER AVE
OVERBROOK HS.
MANN
PRESTON
LEIDY
LEVICK
63RD ST
59TH ST
LANSDOWNE AVE
HANNA
SHOEMAKER
BLANKENBURG
MILLER
GIRARD
HAVERFORD AVE
LAMBERTON
CASSIDY
BISHOP LEARNING CENTER

Legend

Elementary School.... ●

Junior High School.... ▲

Senior High School.... ■

Special Center........ ★

income of the family. Fees range from $0 (for welfare and low income families) up to a maximum of $15 per therapy hour. There is a $25 charge for the initial intake interview.

Intake Process: All requests for service should be initiated by the child's parents and should be directed to the receptionist at the 226-5000 Ext. 340 number. An intake worker will then record relevant information from the clients and obtain a summary of the referring problem. An appointment is given to the parents (usually within a week's time) for the parents and child to be seen by a two-member intake diagnostic team. Following this intake interview, necessary diagnostic evaluations are scheduled, and the case is presented for staffing. Assignment of a therapist is made at this time and treatment is initiated.

School Referrals: Referrals being initiated by school personnel follow the same procedures as described above. However, it is requested that the parents of a referred child make contact with the intake worker, even if they are being requested to do so by a school staff person.

When action is being taken on a school-based referral a letter is sent to the school counselor stating that the child is being seen at the Center. This is accompanied by a request for school information and a signed parental release form. Notification of therapist assignment is made to the counselor and periodic feedback as to treatment progress is provided.

Children's Services Provided by the Center:

A. Outpatient Services to children and their families include individual, group, family, behavioral and speech therapy. Psychiatric, psychological, educational, and speech evaluations are provided. Medical, neurological and other services are arranged, when indicated.

The mentally retarded child or adult receives an evaluation and the appropriate treatment plan is developed. Arrangements can be made for day care, residential placement, public schooling, private schooling, vocational programs, recreational programs and counseling.

B. Emergency Psychiatric Services are provided through the Crisis Center, located in Temple University Hospital on Ontario Street, between Broad Street and Park Avenue. The Crisis Center offers 24-hour daily psychiatric coverage for individuals needing emergency evaluation and treatment.

C. Psychiatric Hospitalization when needed is arranged by the staff in the Children and Family Unit. Temple Hospital and Hahnemann Hospital facilities are used for this purpose.

D. Special Programs

1. School Consultation - Mental health consultation services are provided to numerous schools within the Catchment Area 5A. Individual and group therapy, counselor and teacher consultation, and

staff development are among the services currently being provided.

2. Partial Hospitalization School Program - A special program is being operated in the William Dick School for kindergarten and first grade youngsters. Twenty youngsters evidencing significant learning and/or emotional problems are given intensive remediation within a specialized referral classroom. Remedial education, social work, psychological, psychiatric, and medical services are included in the treatment program.

3. Developmental Disabilities Program - This program is designed to provide educational services to mothers of "high risk" infants and children with marked developmental delays. Specially trained child care workers teach the mothers how to provide necessary sensory, cognitive, and emotional stimulation to maximize the child's developmental potential.

II. Student Demonstration Project

The Student Demonstration Project is an experimental project in the prevention of alcohol abuse. This project is attempting to pilot new methods for preventing the abuse of alcohol among children and adolescents through the development of coping capacities and the learning of responsible decision-making techniques.

Funded as a demonstration project by the National Institute of Alcohol Abuse and Alcoholism, the Student Demonstration Project works with 120 elementary, junior high and senior high school students from the North Central Philadelphia area. These students have been chosen from a few select schools in the Catchment Area. Students are involved in responsible activities five days a week including the tutoring of younger students and the development of alcohol prevention posters and films. It has demonstrated its effectiveness in improving the students' academic performance, reducing school drop-out rates and disciplinary problems.

III. Adult Outpatient Services

The Adult Outpatient Services, commonly referred to as the Psycho-Social Clinics, provide mental health treatment and psychological support services to persons 16 years of age or older. Persons seeking Adult Outpatient Services may either walk in or be referred by relatives, social agencies, civic organizations, or other Units within the Center.

The Adult Outpatient Services are composed of six satellite clinics, a Home Visiting Team, a Saturday Morning Clinic and a Family Counseling Unit. The services provided by Psycho-Social Clinics include individual counseling or therapy, group counseling or therapy, vocational counseling, medication, and referral services.

IV. Emergency Services (Crisis Center)

The Crisis Center provides 24-hour psychiatric emergency care to all residents and non-residents in the Catchment Area. Patients come or are referred to the Crisis Center from many different sources. A person who feels that he has a psychiatric problem may walk in off the street or be brought in by members of his/her family for help. Clients are also referred from private and public community agencies, law enforcement agencies including the courts, Temple University Emergency Services, and other health centers.

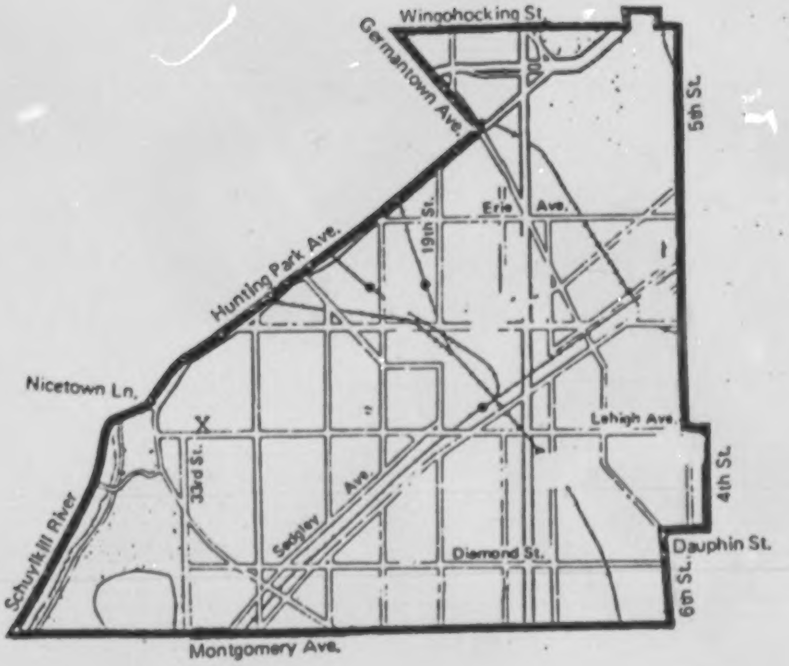
Persons who are admitted may remain in the Crisis Center for a maximum 72-hour observation period. While in the Crisis Center, the client's problems are evaluated and either psychiatric or medical treatment may be advised. The client may then, if necessary, be hospitalized at Temple University Hospital with which NCPCMH/MRC

> has a contract. After the client's condition stabilizes, he/she is then released and, usually, referred to the appropriate Unit within North Central or to other mental health centers for extended and/or follow-up treatment.

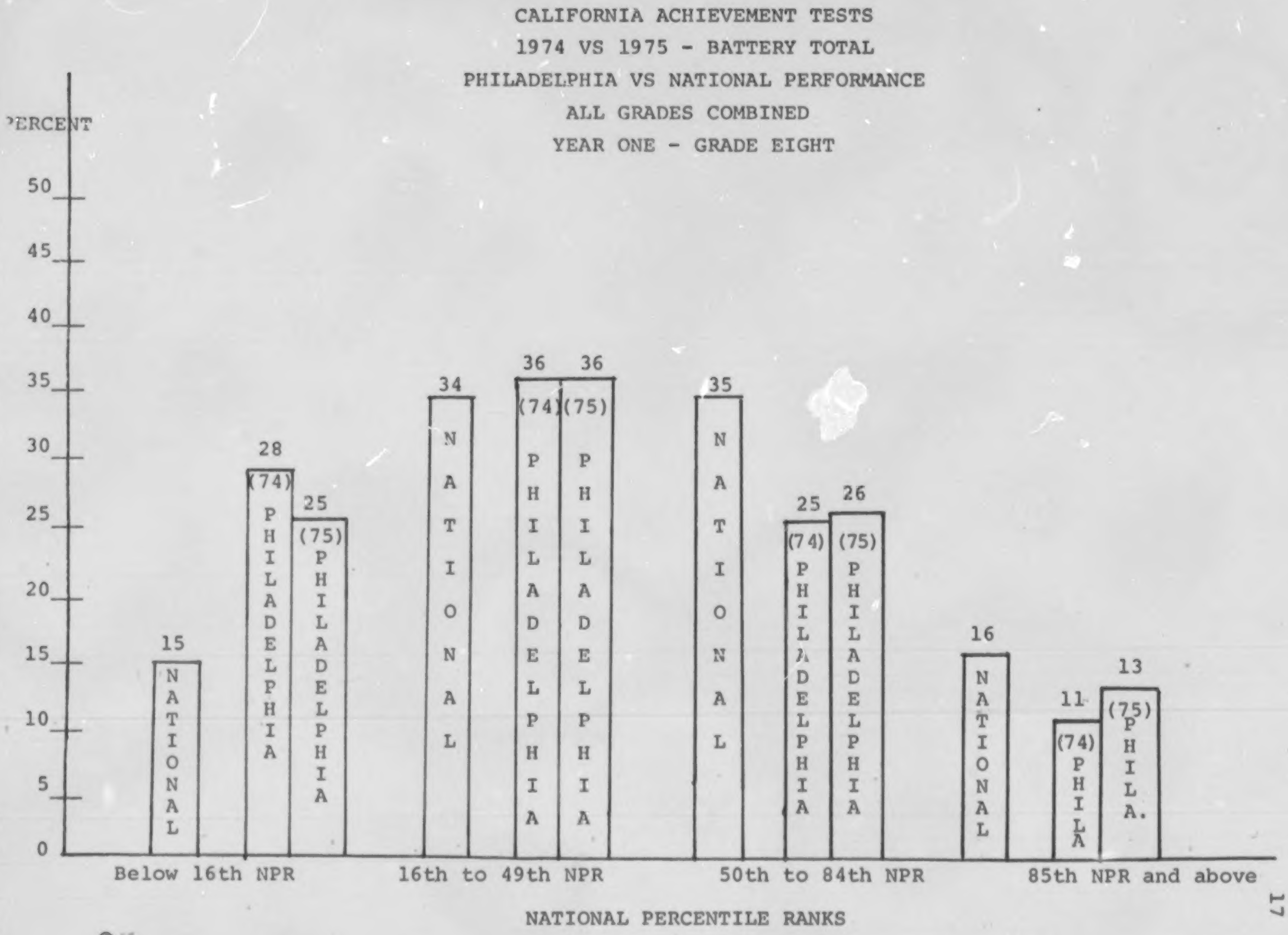
Newspaper headlines constantly indicate that students in Philadelphia inner schools score below the national norms. Special efforts utilizing federal funds such as Title I early childhood programs and intensified reading instruction in the late 1960s improved the situation. The Philadelphia School System's Office of Research and Evaluation indicate that even though many of the children still score below national norms on the California Achievement Tests, the intensified help has resulted in gains in grades one to eight as shown in the following charts.

CATCHMENT AREA #5A

POPULATION: 208,000
North Central
Community Mental Health and
Mental Retardation Center

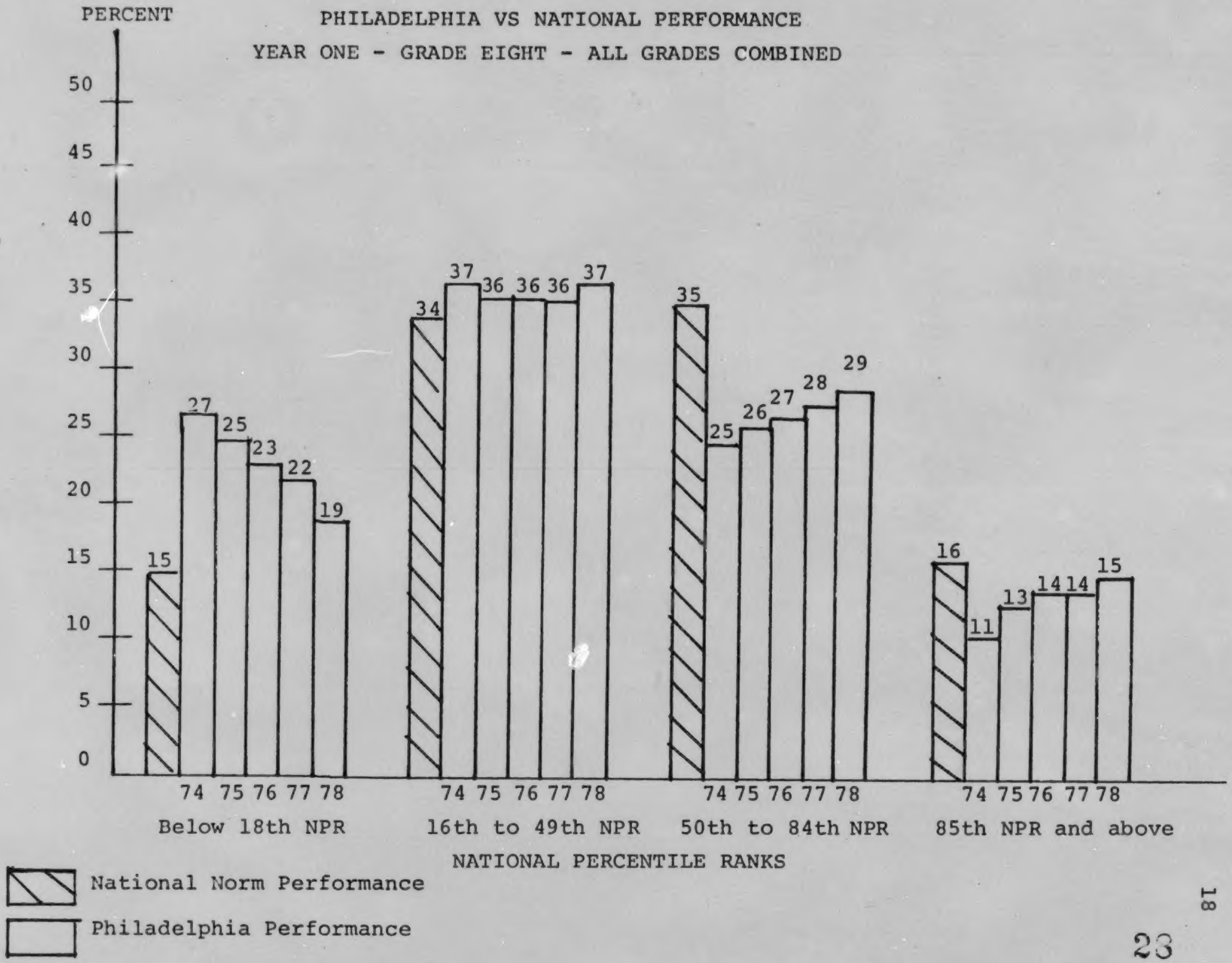

Wingohocking St.
Germantown Ave.
5th St.
Erie Ave.
19th St.
Hunting Park Ave.
Nicetown Ln.
X
Lehigh Ave.
4th St.
33rd St.
Sedgley Ave.
Dauphin St.
Diamond St.
Schuylkill River
6th St.
Montgomery Ave.

X - Lehigh School



CALIFORNIA ACHIEVEMENT TESTS
1974 VS 1975 - BATTERY TOTAL
PHILADELPHIA VS NATIONAL PERFORMANCE
ALL GRADES COMBINED
YEAR ONE - GRADE EIGHT

CALIFORNIA ACHIEVEMENT TESTS
BATTERY TOTAL
PHILADELPHIA VS NATIONAL PERFORMANCE
YEAR ONE - GRADE EIGHT - ALL GRADES COMBINED



Test scores in the upper grades did not show as much improvement because those students were already in school in the late 1960s and did not receive the intensified help. The following data released by the Office of Research and Evaluation shows this.

In reading the percentages of pupils scoring below the 16th percentile were as follows:

Grade	1	2	3	4	5	6	7	8	9	10	11	12
1978	8	9	16	18	24	21	25	24	25	32	38	36
1977	8	9	18	19	26	22	26	28	28	36	41	36
1976	9	9	20	21	27	24	29	29	29	37	41	36
1975	8	10	21	22	27	25	29	28	30	38	39	34
1974	11	18	23	24	31	29	35	32	34	41	40	36

Educators in the Philadelphia School System are hopeful that the trend of improvement in test scores will continue.

ASSESSMENT OF NEED

The counseling supervisor contacted the district superintendent to resume the mobile mental health program. She was still receptive to the program and gave permission for it to begin.

Even though our program was delayed, the need for additional help in providing counseling and mental health services increased. One counselor assigned to Lehigh School could not possibly provide all of the counseling services. In addition to responding to referrals by school staff, a resource room for students needing counseling services and special teaching techniques and two additional special education classes were organized. The counselor's service was needed in arranging for evaluation, counseling and working with the families of students assigned to these new classes. The counselor who had previously been assigned to the school was dropped because of low seniority in the school system. An experienced counselor with more seniority who was a second counselor in another elementary school was transferred to Lehigh. However, since she was new to the school there was a period of orientation for her.

A mental health agency that could provide some help to the counselor in working with the students and their families was welcomed.

In addition Public Law 94-142 [27], which mandates a free education and supportive services to the handicapped, was also being implemented. This created the need for additional counseling services. However, because of the financial crisis of the school district, additional counselors could not be hired. Even those counselors who lost their jobs were not restored. As a result, the one counselor in all elementary schools was faced with carrying out all counseling responsibilities.

The school system has also been unable to provide adequate psychological service. Many students wait for months before psychologists are able to respond to counselors' requests for testing to determine the needs of students. The school district has hired more psychologists; however, the impact of Public Law 94-142 has made it necessary to utilize their services in many ways and little additional testing is being done.

The above needs; additional counseling services, implementation of Public Law 94-142, the need for additional psychological services, and the ongoing problem of getting parents to follow through on referrals to the mental health agency reenforced the impetus for a mobile mental health program.

In order to determine the specific needs of the students at the Lehigh School, counseling records and current referrals to the counselors from teachers were analyzed. The counselor's records and statistics given by the mental health agency reflected the following data:

REFERRALS TO NORTH CENTRAL MENTAL HEALTH/MENTAL RETARDATION AGENCY FOR THE SCHOOL YEAR 1976-77

School	Number of Students Referred by the Counselor	Number of Students Whose Parents Made Initial Calls for an Appointment for Intake	Number of Students Whose Parents Followed through after Intake
Lehigh	42	24	6

Eight families unknown to the counselor were also served by North Central Mental Health/Mental Retardation Agency, according to their records, making a total of fourteen families served.

An examination of referral cards to the counselor for the fall of 1977 indicated five main categories of problems. They were:

behavior
learning
adjustment
family
slow learner or mental retardation

Table 1 that follows shows that there were 57 referrals to the school counselor during the fall of 1977. Most referrals were for possible mental retardation, behavior, and learning problems.

The 14 referrals for behavior ranged from mild to severe problems. The breakdown is given in table 2. It shows that most referrals were for fighting or poor relationships with peers and adults.

The counselor accepted all of the above cases as counselees for individual or group sessions. She also had conferences as needed with their parents or guardian. In many instances the counselor felt that referral to the local mental health agency for additional help was needed. However in follow-up conferences with the local mental health agency, North Central Mental Health/Mental Retardation Agency, very few families reported for help.

When questioned on an informal basis during conferences, the parents who had been referred concurred on the need for special help. They reported to the counselor that

TABLE 1

REFERRALS TO THE COUNSELOR FOR THE FALL OF 1977

Nature of Problem	Number of Students Referred to the Counselor
Behavior	14
Learning	12
Attendance	1
Family Problems	8
Adjustment-Emotional	7
Mental Retardation	15

TABLE 2

BEHAVIOR PROBLEMS REFERRED TO THE COUNSELOR FOR THE FALL OF 1977

Type of Behavior	Number of Students
1. Difficulty relating to peers and adults	4
2. Behavior has recently changed for the worst	1
3. Previous teachers have indicated poor behavior and the pattern continues	1
4. Displays a low frustration level	1
5. Suspended several times for fighting and fighting continues	5
6. Displays a terrible temper and will hit anyone without provacation	1
7. Constantly annoys those around him	1

the teacher of their son or daughter had conferred with them on learning or behavior problems in the classroom and that the situation had not improved. The parents also expressed an inability to take care of the problems themselves. On further questioning by the counselor during conference sessions, parents indicated several reasons for not following through on referrals to the mental health agency such as illness, a lack of transportation, or working.

Of the 14 referrals, only one family followed through. Referrals for learning problems ranged from possible mental retardation to a possible learning disability. The teachers of those students referred for slow learning or for possible mental retardation based their judgments on class performance and achievement testing. The counselor indicated that the students would need psychological testing to determine if there was retardation.

Due to the backlog for psychological testing in the school system, the counselor referred all of the students in this category to the local mental health agency for possible testing and follow-up services.

Table 3 shows that most of the referrals came from the parent or the teacher. Of the 27 referrals, most indicated a concern of the mother with the lack of progress in school by their child. Only one parent had contacted an outside agency for an evaluation before coming to the

TABLE 3

LEARNING PROBLEMS REFERRED TO THE COUNSELOR FOR THE FALL OF 1977

(Including possible learning disability or mental retardation)

Nature of Problem	Number of Students
1. Child seems to have learning problems. Mother wonders if poor eating habits could be a factor	1
2. Teacher indicates that student has been in kindergarten for two years and shows very little progress	4
3. Mother expresses concern over poor achievement of student	9
4. Teacher and mother feel student has potential but he is not achieving	5
5. Mother indicates that testing done at an outside agency shows a possible learning disability	1
6. Teacher indicates that student has had a problem adjusting to the routine of school and exhibits little success in learning	7

counselor. Only three families contacted North Central Mental Health Agency after referral by the counselor. Four additional students were subsequently tested in the school system.

The one attendance problem was referred by the counselor to the home and school visitor. The home and school visitor visits the home to investigate reasons for absence. There was no need for further involvement by the counselor.

Most referrals that fell in the category of family problems centered around the loss of a family member either through death or separation of the parents. One of the eight families referred in this category had moved several times and thus had little stability in any one neighborhood.

The counselor indicated that she referred the eight families to the mental health agency for help; however none followed through. The parents seem to be embedded in their problems and unable to take the first step for help. They indicated that it was easier for them to come to the school and talk to the counselor, but it was an inconvenience or hardship to travel to the agency.

The seven entries for adjustment or emotional problems were in several cases related to family problems. They ranged from stealing to fears of the dark and dying.

The counselor referred all of these cases to the local mental health agency. Of the seven for this category, one parent followed through. She made two visits. However, she discontinued service after she lost her job because she could not afford the carfare any longer.

In summation 57 students were referred to the counselor by teachers or parents in the Lehigh School. Fifty-two of these students were referred by the counselor for outside help from the local mental health/mental retardation agency. This was in addition to counseling provided individually or in groups by the counselor.

Only five of the 52 families referred to North Central Mental Health/Mental Retardation Agency followed through. One family made two visits and then discontinued service. The needs of the students continued to exist which was indicated by continuous conferences of their teachers with the counselor.

It was felt by the supervisor of counseling services for District Four in which the Lehigh School is located, the counselor, the principal and the director of Children and Family Services of North Central Mental Health/Mental Retardation Agency that a mobile mental health program could possibly serve some of the needs of those students whose parents did not bring them to the agency for help. Therefore, the agency would bring the services to the school site making it more accessible to the students and their families.

OBJECTIVES

Phase I

In response to the needs described, the following objectives were established in the development and implementation of the mobile mental health program.

A. Behavioral

1. To increase the number of students referred to the counselor for behavior problems who receive help from North Central Mental Health/Mental Retardation Agency from one to at least 10
2. To increase the number of students referred to the counselor for learning problems who follow through with referrals to North Central Mental Health/Mental Retardation Agency from three to at least 15
3. To increase the number of parents referred by the counselor and who utilize the services of North Central Mental Health/Mental Retardation Agency for family problems from zero to at least six
4. To increase the number of students referred by the counselor and who utilize the services of North Central Mental Health/Mental Retardation Agency for adjustment or emotional problems from one to at

least five

5. To increase the number of students receiving psychological service from North Central Mental Health/Mental Retardation Agency from zero to at least 10

6. To show that at least 25 percent of the students referred to the mobile program will improve in academic achievement

B. Process

1. To make the services of the Mental Health/Mental Retardation Agency more accessible for parents.

SURVEY OF THE LITERATURE

A review of the literature included in Eric, Prise and numerous periodicals indicated no reports of a program involving a mobile mental health approach. There were reports, however, on collaborative efforts between schools and community mental health agencies. The need for such programs was constantly highlighted in all of the readings.

President's Commission on Mental Health

For example, the following data was reported by the President's Commission on Mental Health, whose honorary chairman is First Lady Rosalyn Carter:

> Between twenty and thirty-two million Americans require some kind of mental care--America's mental health problem is not limited to those individuals with disabling mental illness and identified psychiatric problems. It includes Americans who suffer from alcohol and drug misuse, social isolation, poverty, discrimination, anger, depression, anxieties, fears, and physical handicaps, all of which lead to emotional distress. [25]

Other highlights in the report [25] sent to President Carter include the following:

- About 15 percent of the 54 million school age children in this country--8.1 million--need help for various psychological disorders.

- One-fourth of the nation's population at any given time is under emotional stress which produces varying degrees of depression and anxiety.
- At least 1 percent of the population suffers from profound depressive disorders.
- Two million people have or will be diagnosed by professionals as schizophrenics.

The commission further states that "At the present there is no carefully conceived, organized national strategy for the prevention of mental illness . . . " [25]. Mrs. Carter emphatically stated that mental illness touches almost every single family and that every single person has problems, some coping better than others.

Child Development

Several authors, Erikson [10], Dennison [7], Elkind [9] and Laycock [16] discuss the development of the child in the family and the myriad of variables and circumstances that affect that development including mental health problems. Gordon [14], Goode [13] and Mirande [21] discuss the nuclear family in crisis and described the problems discussed earlier that are creating this crisis.

Cowan [5] and Bloom [2] take the situation a step further and discuss steps that schools can take to promote good mental health. In his book Human Characteristics and School Learning, Bloom [2] indicates that most students proceed very similar with regard to learning ability, rate of learning, and motivation for further learning when provided with favorable conditions for learning. It is only when students are provided with unfavorable learning conditions that they become more dissimilar in the respects mentioned above.

Unfortunately unfavorable conditions exist in many homes of children especially those in the inner city, and unfavorable conditions existing in a school tend to reenforce this.

Bloom [1] also states that a positive self-image develops in early childhood during the periods of latency (ages six-11) and adolescence. Mental health is certainly involved with ego development. Bloom [1] thus indicates that continual evidence of success or failure in the school is likely to have major effects on the individual's mental health.

Bloom [1] believes that if the school environment deals with this development of ego and provides the child with adequacy over a number of years, especially in the first few years of school, supported by consistent success over the next four to five years, a type of immunization against mental illness may be provided.

This hypothesis by Benjamin Bloom [1] is reflected in figure 1 and figure 2 that follow.

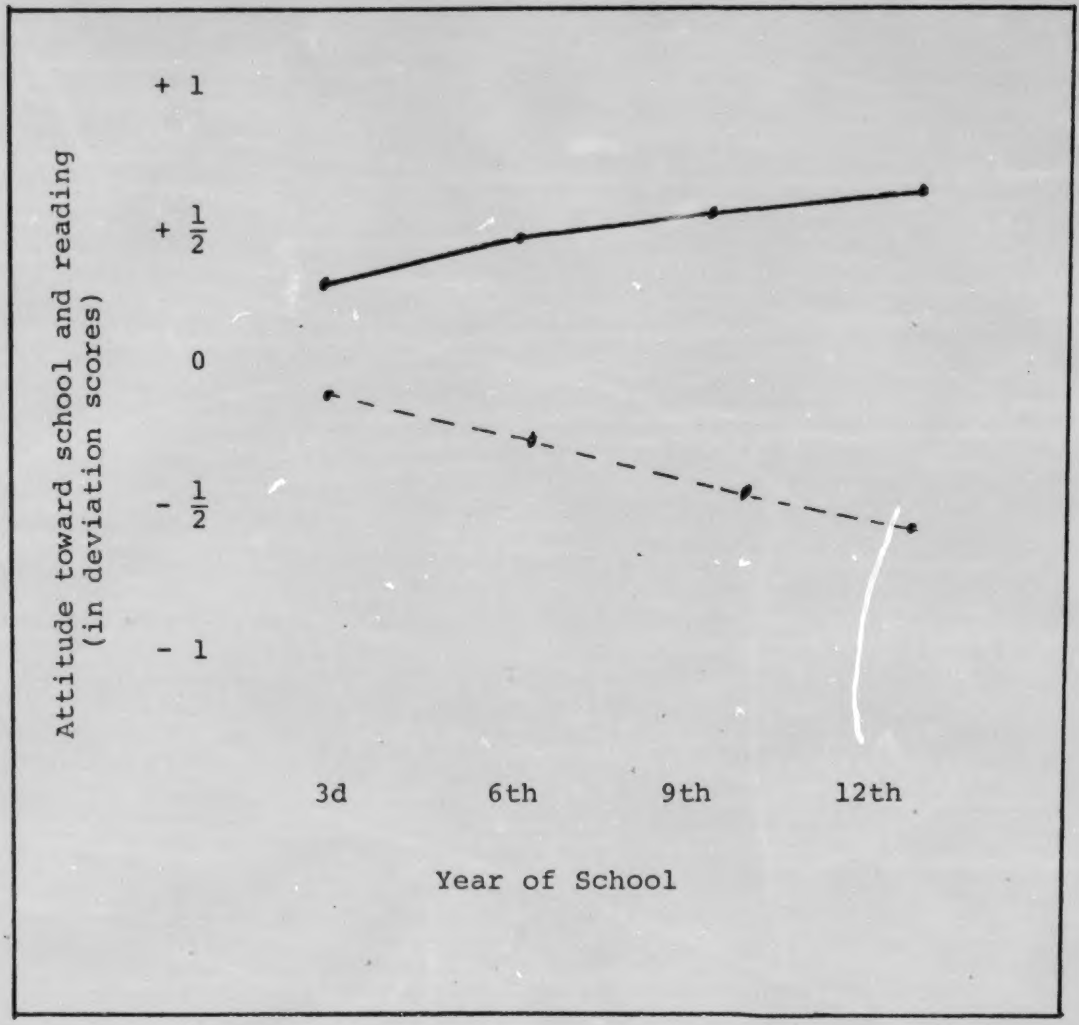


Fig. 1. Affect toward school over years of schooling for successful and unsuccessful students in reading achievement [1].

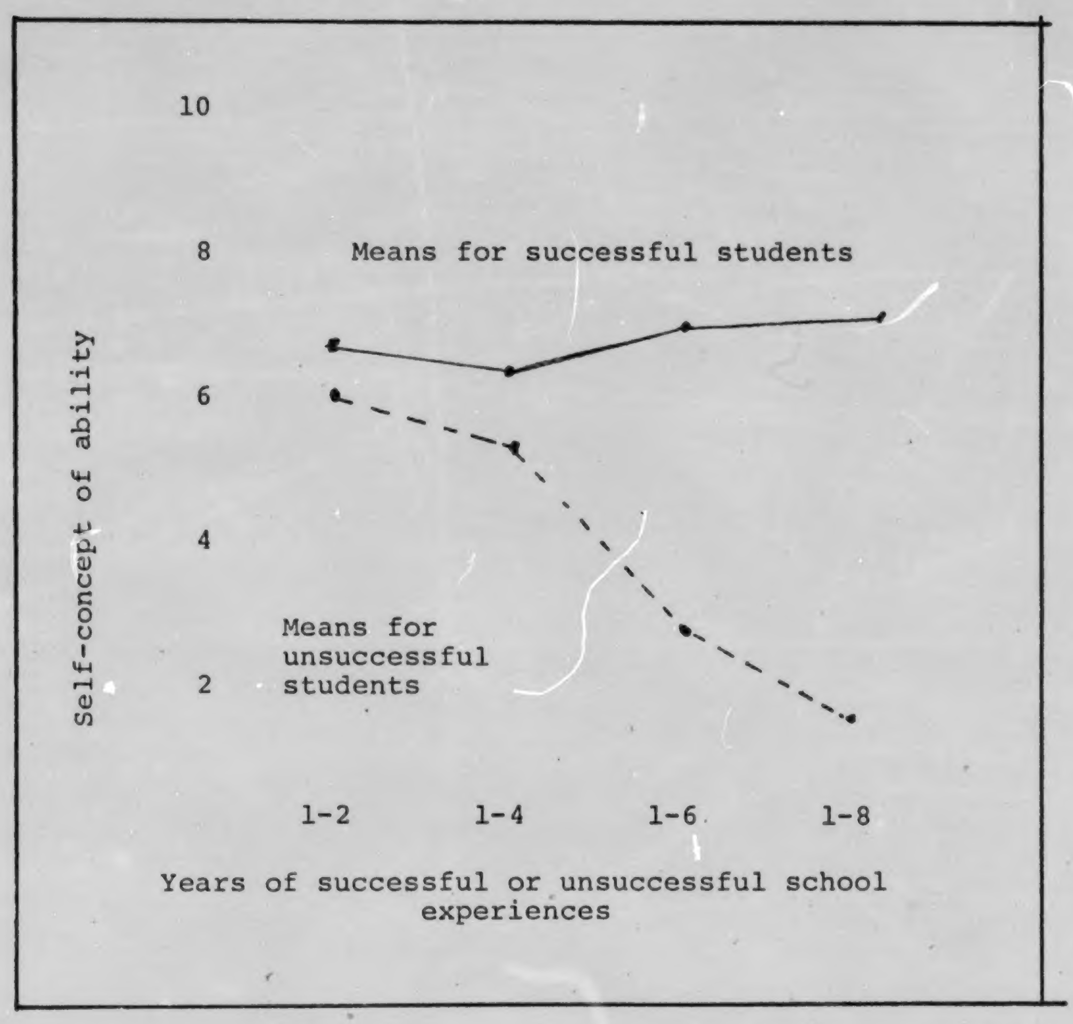


Fig. 2. Self-concept of ability over years of schooling for successful and unsuccessful students [1].

In their article "The Future of Schools and Families: Three Scenarios and a Recommendation," Jerry Debenham and Michael Parsons [6] indicate that one of the prevailing proponents for the failure of schools is the family itself. They state that children are locked into total environments. We cannot effect change by working with the school alone. Something has to be done about the deterioration of the family. We cannot change one without changing the other by means of a total and voluntary reconstruction of the social environment. These is a dire need to merge the educational system with social services to individual parents in order to form an entirely new environment for rearing children [6].

According to the foregoing data by Bloom, Debenham and Parsons, it is important, therefore, to detect and secure service for those students and their families who have special problems. In meeting the needs of all of their students, the schools, particularly in the inner city, must take an active role in securing and providing needed services.

Special Education

Many of the children whom we refer and who need help from the mental health agency seem to be handicapped in some way. Phase II of the practicum will devote a major effort to the collaboration of personnel from the mobile mental health program with school personnel in assessing the problems and needs of those students referred who are handicapped.

Gene Maeroff [18] pointed out that one of the most remarkable turnabouts in our nation's schools is the change in attitude toward mentally and physically handicapped students. He further states that the pendulum has swung so far so fast that already reaction is developing against the priority regulations for the handicapped--often at the expense of the normal child. Court decisions based on a landmark bill in Congress are compelling schools to pay more attention to the country's 3.5 million to 4 million handicapped children. Currently, the handicapped may be getting the edge and the normal child is being pushed into the background. This change in education comes from Congress as a major requirement of Public Law 94-142--the Education for all Handicapped Children Act of 1975 [26] [27].

Briefly the law states the right of all handicapped children to a free education. To ensure that all children are served, they must be located and identified by the local school districts. Individual attention is guaranteed by the provision of an individual educational plan for each child identified as handicapped. The law mandates that student needs be addressed. Short- and long-range goals are established after a needs assessment for each child. Program continuity is guaranteed in that an individualized educational plan must be developed annually and each child reevaluated every two years [27].

The plan must address itself not only to basic education, but to related services including transportation and corrective and "supportive services as speech pathology and audiology, psychological services, physical and occupational therapy, recreation, as well as medical and counseling services" used for diagnosis and evaluation [27].

Since supportive services such as counseling must be provided, key persons responsible for diagnosis and assessment as well as implementation of this aspect of the plan must be involved in the plan development [27]. It is crucial therefore that personnel from the mobile mental health program working with any handicapped students and their parents be involved in school-based evaluation team efforts.

School-Agency Efforts

Mary Lou Reinken [20] describes a school-community mental health effort in the School Counselor, September 1977. Her focus is that helping institutions might be more effective in collaborating with schools rather than competing in arriving at mutually desired goals. They need to be proactive rather than reactive to situations requiring change. She also indicates a few studies whereby creative thinkers suggest alternatives in finding better means for human communication and collaboration.

An effort towards such collaboration written by Vivian Richman is described from a pamphlet distributed by a mental health agency in Maryland. She describes how personnel from a mental health agency in Pittsburgh, Pennsylvania worked as a team with school personnel evaluating and making recommendations for emotionally disturbed children. Richard M. Geer [12] in his article, "A Cooperative Effort: That's the Key," in the May 1976 issue of the School Counselor describes a collaborative effort that he utilized as a counseling psychologist with the East Central Missouri Mental Health Center.

His premise, which is widely supported, is that school counselors do not have time to do all that is expected of them. He points out the two major difficulties confronting school counselors. First, they are expected to meet the demands of administrators, teachers, parents, students, systems and institutions, which is impossible to do. Second, they are "too busy oiling the squeaky wheel to give time to shoring up the wagon" [12]. He proposes that one way of helping counselors is through developing cooperative efforts among care givers.

In his effort, personnel from the mental health agency and the local school worked as a team to help students having learning and/or behavioral problems. Some students were helped as a result of these efforts. However, his experience led him to several conclusions and implications which he suggested [12]. They were:

- The necessity of a cooperative relationship
    - Too frequently the counselor is viewed as the one who has only educational and vocational information, while the mental health worker possesses only clinical information.
- Counselors and mental health personnel need to view each other as colleagues in developing emotionally healthy persons.
    - The more direct, clear and confident the counselor is with the mental health worker, and conversely, the mental health worker with the counselor, the more productive their joint efforts will be. Neither should stand above the other. Each has something to offer.
- Counselors need to take more initiative with community mental health agencies in seeking help for students. There should be no seller and buyer, no giver or taker. It must be a cooperative effort.

In the research, several variables also surfaced in predicting whether students and/or their families would contact and follow through on mental health services. They are summarized in an article by Anthony P. Conti [4] in the Spring 1975 issue of the Journal of School Psychology. They are: [4]

- Confidence in the school counselor
- Expressed confidence in the agency to provide service by the counselor
- The naming of a specific counseling resource for a student and/or family
  - Families often do not realize what they are seeking in going to a mental health agency, and confusion on where to go enters.
- The number of individuals involved in the decision to to refer a student or family.
  - Contact appeared more likely when two or three members of the school personnel determined the necessity for referral.

This is a complex variable, for Conti [4] refers to an article, written by Dr. N. Brill, "Social Class and Psychiatric Treatment," that when only one individual (in all cases, the school psychologist) or more than three individuals determined that a referral should be made, contact was less likely. He emphasizes the complexity of this variable and the need for additional investigation.

Other variables cited were:

- High motivation for help
- Higher socioeconimic strata more likely to make contacts compared to lower socioeconomic strata
  - This could be related to many other variables.
- The number of conferences the family has had with the the counselor and school personnel.
  - Contact became more likely as the number of conferences increased.

This finding indicates how crucial it is to deal fully with the concerns and resistances of both parents. If one parent accepts and the other is not involved in the conferences, he/she may passively or actively resist.

Certainly in our development of a program with a mental health agency all of these variables had to be considered and dealt with, and this research gave valuable perspective.

Another report by William R. Passons [23] in his article, "Community Mental Health Consultants in Schools," describes the kinds of mental health consultation that can be done to help counselors in schools. Dr. Passons is chief of Consultation and Education for the Northeast Community Center for Mental Health/Mental Retardation in Philadelphia, Pennsylvania.

Dr. Passons indicates that the consultants can work with: [23]

- Administrators in the schools
    - The principal can confer with an understanding person on school-related problems. The consultant may be able to offer feedback and make suggestions for changes in the school
- Teachers
    - Providing help on how to handle students
    - Negative relationships with principals
    - Improving teacher-student relationships
    - Discipline (behavior modification programs)
    - Nonverbal behavior of teachers
    - Working with hostile or unresponsive parents
    - Dealing with their personal problems that affect their teaching
    - Teaching affective education methods
- Counselors
    - Consultation on cases
    - Working with groups of students
    - Developing peer counseling programs
    - Helping counselors cope more effectively within their own organization and their role in the school
    - Dealing with conflicts between counselors and parents, teachers or the principal
- Parents

- Speak at P.T.A. meetings on children and their development
- Meet with groups of parents around a common need such as child management, drugs, sex, etc.

In-Service Programs

Several of the reports describing collaborations efforts with the school and mental health agencies, however, related to in-service programs for participating teachers or internships for mental health staff. Such programs have been held in the Sacramento Unified School District in California and Wilmette, Illinois.

One project in Alexandria, Virginia involved a teacher in-service program to modify the attitudes of 284 teachers toward aggressive behavior in children. No definitive results were obtained according to Judith Krasnow [15] in her report, "Aggressive Behavior Research in the Modification of Teacher Behavior." The teachers were not satisfied with the theoretical content of the workshop. It failed to meet their need for direct technical guidance in classroom management.

Within the Pittsburgh Public School System, mental health services were developed in 1965-66 and the results were good. Special education classes and resource rooms for emotionally disturbed children were described and compared. Mental health professionals working with the program were involved in program planning, evaluation of the children, cooperation with other community agencies and teacher consultation.

This approach seems to underscore a process that seems to be common in the successful programs that were in the research. That is, there must be a demonstrated honest commitment on the part of personnel within both the mental health center and the school system regarding their limitations of experience and a willingness to share together in all phases of the program and to learn from one another.

This process would be incorporated in this practicum.

STRATEGY - PROGRAM DESIGN

Program Description

The mental health services normally provided to students and their families at Lehigh School by the community health agency would be provided by a mobile unit from North Central MH/MR Agency. The mobile unit would function as a new program of the Children and Family Unit of the North Central Mental Health/Mental Retardation Agency. The Children and Family Unit serves children from birth to 18 years of age and the mental retardation component serves all ages.

The mobile unit, a large van equipped with three offices inside, was staffed by a team of mental health professionals from the agency. The purpose of the program was to serve children and families who previously had little or no knowledge of or access to the mental health agency.

As indicated by the needs assessment and research, many of the students were in need of services from MH/MR Agencies.

PROGRAM IMPLEMENTATION

A meeting was held at Lehigh School to determine the procedures to implement the program. Attending the meeting were the following people:

- personnel from North Central MH/MR Agency who would be assigned to the mobile unit
- the assistant director of North Central's Children and Family Unit,
- the principal of Lehigh School
- the counseling supervisor
- the counselor
- a teacher from the school's resource room representing the school staff

Referral

It was decided that students and/or their families would be referred to the mobile mental health program through the regular counseling referral process. Through this process, teachers would confer with the counselor regarding a potential counselee and complete the counseling referral form. In addition, parents or students themselves would make referrals to the counselor.

The counselor, after discussion with the principal, would screen the candidates for possible referral to the mobile mental health program. Some students could be helped by individual or group counseling provided by the counselor or by remediation programs within the school. Those students that could not be helped by the services within the school or whose parents needed extra help would be referred to the mobile mental health program.

The staff from the mobile mental health unit would provide the additional counseling and therapy needed to help with the problems of those students and families referred. They would visit on Thursday afternoons.

Identification of Students

According to Bloom [1], a positive self-image develops during the early years or latency period of a child's development. Therefore, the counselor would try to identify as many of the younger children as possible that could possibly benefit from the mobile mental health program. She would also keep statistical information regarding those students referred for help from the agency and follow through by either of the following means:

- Mobile unit located on the school ground
- Visitation to the agency site outside of the neighborhood
- No follow through

Presentation to Staff and Parents

The program was presented to the school staff and to the Parent-Teacher Association. It was imperative that anyone participating in the mobile mental health program have some concept of what it was.

Both groups were given the following basic information by staff from the mobile unit.

- Definition of a mentally healthy person
    - A mentally healthy person is able to handle life's adjustments and changes
- Symptoms of Poor Mental Health
    - undue prolonged anxiety
    - depression
    - abrupt changes in mood and behavior
    - tension-caused physical symptoms
    - perfectionism
    - habitually falling below potential
- The role of counseling and therapy services provided by the mobile unit in achieving good mental health

The referral process was explained by the counselor. The staff members from the mobile unit explained to the parents that on their visit to the van, there would be necessary forms to fill out for North Central's records and possible billing. Most services, however, would be free as they would be covered by medical insurance or medical assistance. It was strongly emphasized that no family would be denied service because of an inability to cover special costs that might occur.

Staff members and parents responded enthusiastically to the program and indicated a great need for such a service. The mobile unit was also brought to the school site for staff and parents to inspect.

Roles of Participants

The School Counselor

In the Philadelphia School System, the elementary school counselor gives direct counseling service to pupils and their parents in relation to school opportunities and concerns or any problems affecting the child's school adjustment and works cooperatively with teachers and other school personnel in planning for the child. He/she also helps parents and pupils make use of existing school and community services.

The elementary school counselor cooperates with teachers and all other school service personnel in promoting a school climate conducive to the growth, development and education of the pupils. It is the responsibility of the Elementary School Counselor to interpret the scope and purpose of the counseling service to the school and the community and to involve the school staff and community representatives in developing and assessing goals and priorities for the counseling service as it relates to the needs of children.

The specific role of the counselor with the mobile mental health program was as follows:

- to meet weekly in individual or group sessions with those students referred to the mobile mental health program and to keep counseling records on these students
- to have conferences with the parents of students in the program
- to have conferences with personnel from the mobile program on the progress of the students in the program
- to have conferences with the teachers of the students in the program
- to confer with personnel from the mobile mental health program and to work together with the teachers and parents of the students in the program towards a satisfactory adjustment

Staff of the Mobile Unit

The van with personnel from North Central MH/MR Agency would park at Lehigh School every Thursday to provide services to students and their parents. Psychological testing would be provided to those students in need of such service and therapy sessions would be conducted with all students and/or their families by a social worker or paraprofessional.

In addition they would confer, as needed, with the counselor and teachers of the Lehigh staff in trying to meet the needs of the students referred to the mobile unit.

The Counseling Supervisor

The counseling supervisor would provide overall leadership for implementation of the program at the Lehigh School. This would include:

- development of the program with the new director, Dr. Clark, of Children and Family Services for North Central MH/MR Agency
- assisting in the introduction and development of the program at Lehigh School
- conducting progress meetings on the mobile mental health program to discuss concerns and needs with representatives from the school staff, parents and North Central personnel
- assisting in the development of procedural guidelines with North Central staff and the school principal for implementation of the program through the school counselor
- providing supervision and guidance to the counselor as she implemented the program
- evaluating and making recommendations for further use of the program

The School Principal

The school principal would convene, and participate in all of the planning sessions for the mobile mental health program. He would also participate in progress meetings for the development as well as in the implementation of the program.

Implementation

Referral

In the Philadelphia School System there is an official form to be used by teachers in referring students to counselors. Figure 3 is a sample of that form. It is not mandatory to use this form because there are situations whereby a direct conference with the counselor would be more fruitful or because of the confidential nature of the referral. There are also crisis situations that do not permit time for the utilization of the form.

It was decided that the official referral form to the counselor, as shown in figure 3, would be used for potential candidates for the mobile mental health program by the school staff.

There was a need, however, for North Central MH/MR Agency to devise a form that could be utilized easily by the counselor in subsequent referrals to the mobile unit staff. After a meeting with the mobile mental health staff, the principal, the counseling supervisor, and the

DIRECTIONS: Ordinarily this memorandum should be sent to the counselor in advance of the pupil

Last Name of Pupil	First Name and Initial	Grade Section or Book Number	Date of Birth Month Day Year

Residence

Adviser

Parents' Names

Telephone

Name of Counselor to Whom Referred

Date of Referral

Reason for Referral:

Suggested Time for Conference with Counselor in Regard to Pupil

Referred by (Name)

Position

Form CEH 47 - Referral of Pupil for Counseling--School District of Philadelphia (Oct. 1973)

Fig. 3. Counseling Referral Form

counselor, a form was developed. Figure 4 is a sample of the form utilized.

Selection of Students

Students were referred to the counselor by teachers, parents, the principal or by students themselves. The counselor, in following normal counseling process, inspected the cumulative scholastic record, the attendance record and the medical record of each student referred. Class observations were made by the counselor and by staff of the mobile unit if necessary. Conferences were held with the teachers, the school nurse and parents as needed.

Additional conferences were held with those parents of students who could benefit from the services of the mobile unit. The parents were given every opportunity to talk and to ask questions from the counselor and/or staff from the mobile unit before beginning the program.

After parental involvement and the willingness of the parent to refer their child to the mobile mental health program, the referral form, which is shown in figure 4, was filled out by the counselor and submitted to the staff of the mobile unit.

In addition, the counselor requested parents to sign a release of information form as shown in figure 5. This is necessary for school personnel, such as the counselor, to share information on school records with outside

NCP CMH MRC NORTH CENTRAL PHILADELPHIA COMMUNITY MH/MR CENTER

Beury Building . 5th Floor . 3701 N. Broad Street . Philadelphia, Pa. 19140 . Phone (215)226-5000

Turner C. Johnson, Jr., M.D., Director

REFERRAL INFORMATION

NAME: ________________ ADDRESS: ________________________ PHONE NO.: ____________________

BIRTHDATE: ____________ AGE: ______________ SEX: ______________ GRADE: ____________

TEACHER: ________________________________ SCHOOL: ________________________________

PRESENTING PROBLEM: ____

____

____

BRIEF FAMILY HISTORY AND CURRENT LIVING SITUATION (include no. of family members, relatives, friends, living in the home) ____

____

____

____

____

EDUCATIONAL INFORMATION (include such information as any testing, special class placement, repeated grades, academic functioning) ______________________________

____

____

____

____

PARENTAL PERCEPTION OF THE PROBLEM: ____

____

____

____

____

SIGNATURE OF REFERRING PERSON: ____________

A COMMUNITY SERVICE OF THE PHILADELPHIA GROUP MENTAL HEALTH/MENTAL RETARDATION ASSOCIATES, INC.

AFFILIATED WITH TEMPLE UNIVERSITY HEALTH SCIENCES CENTER

Fig. 4. North Central Referral Form

Principal ______________________

I______________________________, Parent, Guardian (Underline one)
(Name of Parent or Guardian)

of______________________________, hereby give my Permission for
(Name of pupil)

______________________________ ______________________________
(Name of Agency)

To release to, and accept from______________________________ School

information about my child______________________________
(name of child)

It is understood that this information will be considered confidential and used to facilitate my child's adjustment in school.

Signed______________________
(Parent)

____
(Address)

Fig. 5. Authorization for the Release of Information

agencies.

Counseling

The counselor kept an ongoing record on the official counseling record forms for each student referred to the program. (See Appendix on page 240). Each student was given a time in the weekly schedule of the counselor for individual and/or group counseling. Teachers were also asked to submit data on each child. The request for information by the counselor from the teacher is shown in figure 6 on page 61.

An analysis of the information on the referral forms and from the counseling records indicated relevant data. Table 4 shows that there were 36 participants. Most of the students were from one-parent families and residing with the mother. Of the 36 referrals, only eight resided with both natural parents. Three students resided with two parents with one being a stepfather or stepmother. Most students were from grade four. Only five children had no brothers or sisters. The average number of siblings was three.

Table 5 shows the nature of the referral and their educational achievement at that time. Most of the referrals were for disruptive behavior. This means that the behavior or activity of the student interfered in some way so that the learning process in the classroom was

SCHOOL DISTRICT OF PHILADELPHIA

LAST NAME OF PUPIL	FIRST NAME & INITIALS	SEX	DATE OF BIRTH
__________________	_____________________	___	_____________

Grade________ADDRESS___________________________ZONE_____PARENTS

__________________   __________________

Has pupil had a psychological exam within the past year ______________________
If "Yes," give date_______________19_____.

1. Brief statement of the problem the child presents (Reason for Referral) (Information or desired outcome from this examination.)

2. School adjustment (date of first admission to Philadelphia Public School, attendance and any significant school history such as grades repeated and P.V.A. scores, and date of last individual psychological examination.)

3. Achievement Levels - Teacher's estimate of child's school proficiency in reading, arithmetic and spelling in terms of grade levels, net scores on achievement tests. (If child in R.E. class, include state of his growth there.)

4. Medical and developmental history as reported by school records and parents. (Include date of last school medical examination, child's visual and auditory acuity, childhood diseases and comments by school physician or nurse.)

5. Results of parental interviews.

6. Measures school has taken to alleviate problem (school and community resources).

Fig. 6. Request for Information for the Counselor

TABLE 4

FAMILY COMPOSITION OF REFERRALS TO THE MOBILE MENTAL HEALTH PROGRAM

Name	Grade	Age	Number of Parents in Home	Number of Siblings
1. Stephen	5	11	1 (mother, divorced)	4 (older--3 married)
2. Ervin	Special class*	9	1 (mother, parents separated)	3
3. Harold	5	10	1 (mother, parents separated)	1
4. Calvin	Special class	12	2 (stepfather)	0
5. Glynn	3	8	2	2
6. Lonnie	4	10	1 (mother)	8
7. Torrance	4	10	2	2
8. Miriam	Kdgtn.	6	2	4
9. Robin	4	9	2 (mother dead stepmother)	2
10. Mark	1	6	1 (mother)	0
11. Nikita	3	8	1 (mother)	3

TABLE 4--Continued

Name	Grade	Age	Number of Parents in Home	Number of Siblings
12. David	Special class	8	2 (stepfather)	2
13. Jackie	Special class	9	1 (mother)	3 (1 with mother, 1 with father, 1 with grandmother)
14. Herbert	3	7	1 (mother)	3
15. Antoinette	4	9	1 (mother)	3 (sister of Herbert)
16. Kenard	3	8	1 (mother)	3 (older sister, age 16, is pregnant)
17. Brian	3	9	1 (parents separated)	1
18. Keith	4	9	1 (mother)	2
19. Towanda	2	7	1 (mother)	1
20. Maurice	4	9	1 (mother)	2
21. Terri	5	10	1 (mother)	3
22. Tamiko	2	8	1 (mother)	2
23. Laverne	3	9	0 (lives with aunt, mother is living)	0

TABLE 4--Continued

	Name	Grade	Age	Number of Parents in Home	Number of Siblings
24.	Chester	2	8	1 (mother)	2
25.	Gregory	Special class	8	2	4
26.	Darrell	4	10	2	3
27.	Kevin	5	10	1 (mother)	7
28.	Angela	4	9	2	4
29.	Stephen	4	10	1	3
30.	Daryl	4	10	0 (aunt)	0
31.	Eddie	3	9	1 (mother)	0
32.	Tasha	5	10	1 (mother)	3
33.	Maurice	4	9	1 (mother)	2
34.	Lisa	2	7	2	3
35.	Laverne	4	10	2	1
36.	Norman	4	10	0 (grandmother)	2

*Special class = slow moving class.

TABLE 5

NATURE OF PROBLEM AND EDUCATIONAL RECORDS OF STUDENTS REFERRED TO THE MOBILE MENTAL HEALTH PROGRAM

Name		Nature of Problem	Educational Record
1.	Stephen	Slow learner	Spent two years in kindergarent--continuous lack of achievement
2.	Ervin	Slow learner and disruptive	Continuous lack of achievement
3.	Harold	Disruptive behavior and learning problem	Continuous lack of achievement
4.	Calvin	Talks very little and learning problem	Continuous lack of achievement
5.	Glynn	Disruptive behavior	Bright child and functioning on grade level
6.	Lonnie	Excessive absence affecting rate of learning	Functioning below grade level
7.	Torrance	Learning problems	Functioning below grade level
8.	Miriam	Learning problems and daydreams	Functioning lower than grade level
9.	Robin	Learning problem	Poor school achievement
10.	Mark	Learning problems	Not working up to potential

TABLE 5--Continued

Name		Nature of Problem	Educational Record
11.	Nikita	Learning problem	Unable to conform to classroom routines
12.	David	Slow learner and poor behavior	Poor achievement
13.	Jackie	Learning problem	Continuous lack of achievement
14.	Herbert	Disruptive behavior	Normal progress
15.	Antoinette	Disruptive behavior	Normal progress
16.	Kenard	Disruptive behavior	Normal progress
17.	Brian	Disruptive behavior and learning problems	Not working up to potential
18.	Keith	Disruptive behavior and learning problems	Poor achievement
19.	Towanda	Behavior--temper problem	Normal progress
20.	Maurice	Behavior--poor peer relationships	Normal progress
21.	Terri	Behavior--poor peer relationships	Lack of school achievement
22.	Tamiko	Emotional problems	Functioning below grade level

TABLE 5--Continued

Name	Nature of Problem	Educational Record
23. Laverne	Behavior--emotional	Normal progress
24. Chester	Behavior--emotional	Normal progress
25. Gregory	Behavior--learning problems	Continuous lack of achievement
26. Darrell	Behavior--emotional	Below grade level
27. Kevin	Emotional--learning problems	Not working up to potential
28. Angela	Disruptive behavior and learning problem	Not working up to potential
29. Stephen	Disruptive behavior	Normal progress
30. Daryl	Disruptive behavior	Functioning at grade level
31. Eddie	Disruptive behavior	Functioning at grade level
32. Tasha	Disruptive behavior	Poor achievement
33. Maurice	Learning problems	Poor achievement
34. Lisa	Learning problem	Below grade level
35. Laverne	Learning problem	Below grade level
36. Norman	Learning problem	Not working up to potential

disrupted.

A total of 20 referrals were for disruptive behavior, 14 for learning problems and two for other categories.

Only 11 of the 36 students were making normal progress or functioning at grade level. The remaining 25 were making little or no progress educationally.

Mental Health Services Provided

After referral by the school counselor, the staff of the mobile unit conducted an intake evaluation. At this first session on the unit, parents and the children were seen together. The purpose was to bring the entire family together so that everyone's ideas about the problem could be shared. All appointments were made through the school counselor.

When the family arrived, the following stages occurred in the intake interview:

- a social stage in which the therapist met and chatted with the family
- a problem stage in which the inquiry was made about the presenting problem
- an interaction stage in which the family members were asked to talk with each other
- a goal-setting stage where the family was asked to specify just what changes they desire

The interview ended by setting an appointment for the next time, with the entire family or with some part of it. At the second session a plan for reaching the goals made by the family and therapist was made jointly. Subsequent sessions involved any of the following techniques that were utilized as needed:

- conferences relating to counseling with student and/or members of the family
- testing by the psychologist to assess educational needs
- therapy provided to the student and/or members of the family
- referral to other agencies for additional services that were needed

The types of therapy available included individual, group, and family therapy.

In the Philadelphia school system, counselors do not provide therapy in the strictest sense. Therefore, most therapy is provided by community mental health agencies. It is utilized by the staff from mental health agencies to help solve some of the many psychological problems that their clients may be experiencing. Therapy in outpatient service means many things. In some cases it might mean talking over a situation which is making a person feel confused. In other cases it might mean helping to solve a social problem which is making a person's life difficult.

In still other cases it might mean getting a family together to try to make things go more smoothly at home. In all of these cases, there is a problem, a person or a family who has that problem, and a therapist who is there to help solve the problem.

What happens in therapy sessions varies depending on the problem, the therapist, and the client involved. Usually the therapist will ask questions about the problem, how it arose, what has been done to solve it so far, and how the person or family feels about it. Sometimes the therapist will offer a solution, but more often he/she will work with the client to come to a solution together. There is nothing mysterious about therapy. A therapist is merely a trained person helping people who have emotional or psychological problems. They are willing to help you solve the problems. Most of the therapists at North Central MH/MR Agency, including the one that provided service on the mobile unit, have graduate degrees in psychology, psychiatry, or social work.

In addition, staff from the mobile unit gave occasional presentations to the school staff on promoting good mental health in the school. According to Laycock [16], teachers should not merely be technicians imparting knowledge, but vitally concerned with the total growth and development of the child. He states that too often teachers spend too much of their time reacting to classroom problems rather than utilizing constructive efforts to promote the mental health of their pupils.

Staff from the mobile mental health unit used the following approach in their presentations to the school staff. Their initial presentation centered around three questions. They indicated that to adequately build mental health in their pupils, teachers, supervisors, principals and other administrators should actively seek answers to three questions. They were:

- Why should the school concern itself with mental health?
- What are the characteristics of a mentally healthy pupil?
- How can a school provide the kind of conditions for living and learning which will promote the mental health of its pupils?

These questions were answered and discussed in subsequent presentations to the school staff. The school counselor utilized material from Laycock [16] as well as the staff from the mobile unit in the presentations. The areas covered were:

1. Why Concern for Pupil Mental Health [16]

This seemed like an obvious concern for all educators; however, salient facts on this question were covered. The input was that occasionally educators feel that mental health is not the concern of the school. Its job is solely that of intellectual development. However, even on that basis, the school has no choice but to promote emotional stability and maturity in its pupils. There is evidence that emotional factors hinder learning, that they frequently lie at the basis of underachievement and that they are prominent in school dropouts. The problems that affect the emotionally upset, the insecure or inadequate child impede learning. Consequently, even the teacher who sees education only as getting children through examinations, must interest himself in his/her student's emotional health. Most teachers are genuinely concerned with helping their pupils achieve maximum self-realization and become mature citizens able to make a contribution to their fellow men.

2. What is Good Mental Health [16]

Since a definition of mental health involves a value judgment, there is no consensus as to what mental health means. However, there is reasonable agreement about some of the characteristics of a mentally healthy person in our society.

First, a child's attitude to himself (his self-concept) is thought to be of prime importance. The mentally healthy child feels comfortable about himself and reasonably secure and adequate. He neither underestimates nor overestimates his own ability. He accepts his shortcomings. He has self-respect, self-confidence and self-reliance. He strives to realize his potential and his talents.

Second, the mentally healthy child learns to have reasonably effective relationships with his peers, his teachers, his parents, and other adults. He is able to be interested in others and to love them. He has satisfying friendships. He can feel part of the group without being completely dominated by it. He learns to do things for others.

Third, to become a mentally healthy adult, a child must learn to face reality in reasonable fashion and to cope with a fair degree of anxiety and stress. He must learn to think for himself, to make his own decisions, and to do something about his problems as they arise. He must learn to balance his life so that he can handle his emotions, his instincts and his conscience without undue conflict; he needs to be able to set realistic goals.

Each of the above objectives is influenced for good or ill by what goes on in school every day. How a child feels about himself, how he reacts to others and how he tackles life's problems, are all affected by the interrelationships of teachers, pupils and administrators methods of teaching and discipline, and by administrative policies and the provisions that are made for individual differences. If teaching is to be effective, it must consider how it will affect the mental health of the students.

The teacher's mental health is also very important in fostering the mental health of pupils. Administrators need to concern themselves with three things in fostering good mental health for teachers. They are:

- providing working conditions which will preserve and enhance the teacher's mental health
- encouraging and promoting the teacher's professional and general intellectual growth
- finding ways of increasing the self-understanding of the teacher

The psychological conditions of work are often the most important. The climate of a school, the tone set by the superintendent down to the principal, as well as the teacher's relationships with his fellow-teachers, counselors, supervisors, and parents, profoundly affect the teacher's mental health, and in due course, that of his pupils. Poor staff relationships, friction between teachers, and undue criticisms by parents and the public, can do great harm to the quality of teaching and learning in the classroom. Correction of such conditions are often more important than specific attempts to improve teaching methods.

The impact of discipline and teaching methods on mental health was also discussed with the teachers. It was emphasized that discipline should not be the equivalent of punishment. Rather, it is a form of learning which leads to self-control and self-direction. Like other forms of classroom learning, discipline should enhance a student's concept of himself, improve his relationships with teacher and classmates, and enable him to direct his own behavior more effectively and to deal with his personal problems of living. Teachers, therefore should examine their methods of discipline in the light of what they do for the emotional growth of the student.

The methods used in teaching can also be basic in meeting, or frustrating the emotional needs of pupils. Emphasis should be on flexibility so that pupil growth can be encouraged through creativity, investigation, experimentation and active problem solving. Individual differences must also be considered. If a pupil's self-image is as important as mental hygienists believe, then this image is enhanced by success and recognition, and damaged by continued failure to achieve. Since children have basic needs for achievement and recognition, it follows that teachers should provide them with work at which, with effort, they can succeed.

The present explosion of knowledge is challenging the conception of education as being chiefly the acquisition of specific knowledge and skills which every child should acquire, and which will last a lifetime. Today facts and skills become rapidly outdated. As a result, education may be forced to shift its emphasis to the mental health concept of pupil growth, whereby each child develops skills in problem solving, critical thinking, investigation, experimentation and creativeness, all in accordance to his own pattern and rate of growth [15]. Certainly this has already started with Public Law 94-142 in the new guidelines for educating the handicapped.

The teachers responded enthusiastically to these presentations by the mobile mental health staff. There were also many challenges and questions directed to the staff. In conclusion, however, the teachers felt that the mobile mental health program was a needed and desired program for the students and their families.

The staff from the mobile unit under the auspices of the school counselor made similar presentations to parents at Parent Teachers Association meetings. They too indicated support for the ongoing program.

Monitoring

The counseling supervisor worked very closely with the counselor as she implemented the mobile mental health program. In its initial operation, the counseling supervisor was there to observe and give any suggestions to the counselor as well as support.

Progress meetings were held periodically to assess the program. The meetings were convened by the principal. Attending the meetings were the following:

- principal
- counseling supervisor
- counselor
- a staff representative
- the mobile mental health staff

Occasionally the assistant director of the Children and Family Unit of North Central MH/MR Agency or the administrative assistant to the district superintendent would attend a meeting.

Some of the problems that occurred that were discussed at the meetings and subsequently resolved were:

- Scheduling of Students
  - Staff from the mobile unit indicated that occasionally a student was late coming to the van, and thus they were not ready for the next client.

    This was resolved by the counselor speaking at a staff meeting on the importance of teachers releasing the students on time. The counselor also sent reminders to each teacher every Thursday morning with a request for notification if the student was absent.

If a student was absent, the counselor either scheduled another student or utilized the time to confer with the mobile mental health staff about certain students.

. Location of the Van

. Initially the van parked on the school yard close to the entrance. However, it was an obstruction to recess activities and attracted children who due to their natural curiosity wanted to enter.

This problem was resolved by parking the van on the street in front of the school. It was therefore out of the school yard and not accessible to students. Students and/or their parents could enter from the entrance facing the curb.

. Impatience of Parents and Teachers

. A few parents and teachers expressed concern that little change was seen after a few sessions on the mobile unit.

The counselor responded to this concern by explaining again the intake process. She also explained that in some cases, psychological and/or psychiatric testing was needed and that it took time to give and receive reports from these evaluations. The counselor also explained that counseling and therapy is not a fast process. Each student and/or his/her families respond differently to the process. There are also variables existing at times over which there is little control.

The counselor also arranged for constant feedback to teachers on the sessions with their students and arranged conferences with the mobile unit staff when necessary.

. The Need for Continuous Feedback to the Counselor by the Mobile Unit Staff

. Initially many students were scheduled for the mobile unit leaving very little time for conferences on these students with the counselor and the mobile unit staff. This concern was expressed directly to the counseling supervisor by the counselor.

The supervisor responded to this concern by making this a subject of discussion at one of the progress meetings. The problem was resolved by the staff from the mobile unit giving the counselor verbal reports if time permitted or the sending of written reports on each student's progress.

. Absence of a Parent for Sessions

. Occasionally a parent did not arrive for the scheduled appointment. The student by being present in school, however, was available. Staff from the unit indicated to the counselor, principal and supervisor at one of the progress meetings how imperative it was for parents to be present to discuss and be involved in family interactions and to jointly plan for their child.

The principal responded by speaking to parents at a P.T.A. meeting on the progress of the mobile mental health program, and how imperative it was for parental involvement for success of the program. In addition, the principal volunteered to call personally the parents who were not appearing.

Through the progress meetings, and occasional visitation on Thursdays by the counseling supervisor, the assistant director of Children and Family, and the assistant to the district superintendent, the program proceeded with success.

In addition to the counselor's and the principal's attempts to follow up on students in the monitoring process, Ms. Bruce, the supervising staff member of the mobile unit, also followed up on and monitored the progress or lack of it for each student. Letters were sent and telephone calls were made to parents who did not appear for necessary conferences.

If there was no response to her efforts, a termination notice was sent to the parent. This type of notice was sent to one guardian. After receiving this notice, the guardian-surrogate parent of Robin, contacted the school counselor and sessions resumed. A copy of this letter is found in the Appendix on page 260. Robin's mother committed suicide when Robin was three years old. She seldom sees her father, and her surrogate parent has many responsibilities and problems of her own. As would be expected, Robin's gains were not as great as some other students.

EVALUATION

Data Instrumentation

In order to determine whether the mobile mental health program was successful or not, the performance of the students involved in the program had to be evaluated. The California Achievement Test was used to assess the pupil competencies in the basic skills of all students in the program.

Counseling records were used to indicate the number of students referred for disruptive behavior and how many of these students received help from North Central MH/MR Agency through the mobile unit. These records were also used to determine the number of students who were referred to the counselor for learning and/or emotional problems as well as psychological service and family counseling, and who followed through with referrals to the mobile mental health program. Teachers' reports were also examined.

Data Analysis

Practicum Objective 1

The first objective was to increase the number of students referred to the counselor for behavior problems and who received help from North Central Mental Health/ Mental Retardation Agency from one to at least 10.

Prior to the implementation of the mobile mental health, only one student, who was referred, received help from the agency. Our intention, with the implementation of the mobile program, was to increase this number.

In order to determine if this objective was met, a comparison of the number of students referred to the North Central Mental Health/Mental Retardation Mobile Unit for behavior problems and whose parents followed through was made.

An examination of the counselor's records indicated that this objective was achieved. Table 6 shows that 24 students were referred to the counselor for behavior problems and that 20 of those student were referred to the mobile unit.

After consultation with teachers, and examination of report cards (pp. 252-56), the counselor indicated that all of the students that were referred to her for disruptive behavior and who received help from the staff of the mobile unit improved in behavior. Therefore we

TABLE 6

POST PRACTICUM SURVEY OF REFERRALS FOR DISRUPTIVE BEHAVIOR AT LEHIGH SCHOOL

				Number of Pupils	
Grade	Number of Pupils Referred	Number of Students Referred to the Mobile Unit	Number of Pupils Whose Parents Followed Through	No Improvement	Improvement
K	0	-	-	-	
1	0	-	-	-	
Special class	4	3	3	-	3
2	2	1	1	-	1
3	7	6	6	-	6
4	8	8	8	-	8
5	3	1	2	-	2
6	0	-	-	-	-
Total	24	20	20	0	20

accomplished and exceeded our first objective by attaining a 100 percent follow through.

Objective 2

The second objective was to increase the number of students referred to the counselor for learning problems and whose parents followed through with help for them utilizing North Central Mental Health/Mental Retardation Agency from three to at least 15.

Counseling records revealed that 14 students were referred to her with learning problems listed as the first or primary handicap. (See table 5 on p. 65). However. five of the students referred for disruptive behavior and two of the students with emotional problems also had learning problems. One student's learning problem was due to excessive absence. Therefore a total of 21 of the 36 referrals had a learning problem as the primary or secondary handicap as shown in table 5.

After receiving service from the mobile mental health unit, 12 students were referred to a slower moving class with tutorial help, four were recommended, after psychological testing for the retarded educable class and four were diagnosed as learning disabled. One child was found to be normal in intelligence, but family quarrels and disruptions had decidedly affected his school work. This family was referred for intensive help from the Intramural Unit of the Child Guidance Clinic. This agency provides outpatient and limited inpatient service to children and

TABLE 7

POST PRACTICUM SURVEY FOR REFERRALS FOR LEARNING PROBLEMS (PRIMARY OR SECONDARY HANDICAP)

				Number of Pupils	
Grade	Number of Students Referred	Number of Students Referred to the Mobile Unit	Number of Pupils Whose Parents Followed Through	No Improvement	Improvement
K	3	1	1	-	1
1	4	2	2	1	1
Special reclass	5	5	5	-	5
2	2	1	1	-	5
3	2	2	2	-	2
4	9	7	7	2	5
5	3	3	3	-	3
6	1	0	0	-	-
Total	29	21	21	3	18

their families.

The Intramural program is a special program of the Child Guidance Agency. It receives its name from the Latin "intra" (within), and "murs" (walls). Treatment in the Intramural program is short term--a maximum of 60 days for inpatient service and 120 days for day treatment. It is intended to provide an episode in ongoing outpatient work with the child and the family, offering the opportunity of the development of new strategies to solve the identified problems.

Within Intramural, treatment is delivered by a team of clinicians (a family therapist who is either a psychiatrist, clinical psychologist or social worker--two Child Life counselors--and a psychoeducational specialist). Together they work with the child and the family determining treatment plans and incorporating their findings into a formal contract which details the treatment issues and plans. This contract also specifies ways in which the child, the team and family must involve themselves.

Two apartments are available to the inpatient unit for the treatment or observation of the whole family. By having a family live in one of these apartments for a short period of time, while following a planned therapeutic routine, intensive treatment can be provided to the entire family. For inner-city families with little income, costs are covered by medical assistance.

A lack of clear guidelines regarding the involvement of outside agencies regarding pupil placement and the resistance of the parents due to a perceived stigma impeded the placement of the four students in classes for the educable mentally retarded. These students were already in the slowest moving, special class, of their grade and thus, because of no resolve to the problem, remained in their classes. The staff from the mobile unit referred the parents to their retardation unit for help and the counselor recommended tutorial services.

Therefore our second objective of increasing the number of students served by the North Central Mental Health/Mental Retardation Agency for learning problems to at least 15 was achieved and exceeded. Twenty-one students followed through on referrals and teachers indicated that 18 of the students showed improvement in class.

Objective 3

The third objective was to increase the number of parents referred by the counselor and who utilize the services of North Central Mental Health/Mental Retardation Agency for family problems from zero to at least six.

An examination of the counselor's records indicated that there were family problems involved in 12 of the students referred for disruptive behavior and for all of the students referred for emotional problems. Therefore we had 17 families served by the mobile mental health program where a family problem existed. Table 8 shows the range of problems.

After consultation with the counselor and the principal, three families were referred to the Protective Services Department of the Department of Public Welfare. The Protective Services Department works with families where alleged neglect or abuse to children exists.

As mentioned earlier, one family was referred to the Intramural Program of the Child Guidance Clinic. The remaining families continued to receive therapy from the mobile mental health staff. At times, however, the parents did not keep their appointments due to other pressures or problems in their families. Follow-up calls by the counselor and/or principal improved the situation in most cases.

Thus we exceeded our third objective by 11 families.

TABLE 8

POST PRACTICUM SURVEY OF REFERRALS FOR FAMILY PROBLEMS

Nature of Problem	Number of Families	Those Receiving Therapy	Involvement of other Agencies
Alcoholic parent	3	2	1
Neglect	4	4	2
Abuse	1	1	1
Financial need	6	6	6
Apathy	3	3	1

Objective 4

The fourth objective was to increase the number of students referred by the counselor and who utilize the services of North Central Mental Health/Mental Retardation Agency for adjustment or emotional problems from one to at least five.

Counselor records as shown in table 5 indicated that five students that were referred to the mobile unit had emotional problems as a primary or secondary handicap. All of these students received therapy from the staff of the mobile mental health program.

One student was referred to the Intramural Program. His original referral was for a learning problem and the counselor detected emotional problems before the child was referred to the mobile mental health program. All of these students received psychological testing by the psychologist serving the mobile unit. Two of these students were recommended for further psychiatric evaluations. The counselor arranged for these evaluations through the school district's psychiatric consultant. These were the only two students referred to the mobile unit, where psychiatric testing was recommended. The other students received therapy provided by the mobile mental health program. The results of the psychiatric evaluation for the two students are found in the Appendix on pages 243-50.

One of the students, Calvin, was given extensive psychotherapy by North Central's staff and continues to be involved in the mobile mental health program.

All of the students referred and served by the mobile program for emotional problems showed some progress in class according to teachers' records that are described on pages 97 to 113. Calvin was placed in a class for the socially and emotionally disturbed and is also making progress. Thus we achieved our fourth objective by 100 percent.

Objective 5

The fifth objective was to increase the number of students receiving psychological service from North Central Mental Health/Mental Retardation Agency from zero to at least 10.

All of the students having learning problems as a primary or secondary handicap, which was a total of 17, (see table 5), received psychological testing by a psychologist on the mobile unit. In addition, the five students referred for emotional problems received psychological testing. Therefore a total of 22 of the 36 students referred to the mobile mental health program received psychological testing. We achieved and surpassed our goal of 10.

Objective 6

The sixth objective was to show that at least 25 percent of the students referred to the agency will improve in academic achievement.

In order to determine if this objective was met, a comparison of the February 1978 California Achievement Test Results was made with those for February 1979. Table 9 indicates that most students involved in the mobile mental health program showed some improvement.

Only three students showed no improvement. These were three of the four students whose parents failed to follow through in placement in a class for the educable mentally retarded. Since 33 students improved out of the 36 students involved in the program, the sixth objective was achieved. A total of 92 percent of the students improved academically exceeding the expected 25 percent.

Teachers of all of the students involved in the mobile mental health program indicated improved classroom behavior and/or classroom participation. Most students made some progress in their academic subject areas as indicated in the comparison of February 1978 and February 1979 California Achievement Test Results as shown in table 9. Teachers records and report grades along with counseling data was examined by the school counselor. They represented additional indicators in the monitoring and evaluation

TABLE 9

SUMMARY OF C.A.T. RESULTS AFTER THE MOBILE MENTAL HEALTH PROGRAM

	Number of Pupils		
Grade	No Improvement	Improvement	Total Number of Children
K	-	1	1
1	-	3	3
Special classes	3	2	5
2	-	3	3
3	-	7	7
4	-	12	12
5	-	5	5
6	0	0	0

component. Examples of the initial referrals to North Central Mental Health/Mental Retardation Agency and the current academic records for three students are included in the Appendix on pages

The following account summarizes the records and the degree to which the objectives for academic and behavioral change were met for each participant indicated in table 5 on pages 65-67.

Stephen

Stephen is a fifth grader who has been beset with learning problems since kindergarten. His siblings have done well in school, but Stephen seemed to be affected by his parents' divorce. His mother has long been concerned about Stephen's lack of achievement.

For the second report period in the spring of 1979, his report grades reflect an average of grade C. Previously, his grades were D's and E's. His teacher indicated that "Stephen has shown a more serious effort in the classroom. Progress remains slow, but he seems to be trying harder. Work has been somewhat neater, Stephen participates very much in the classroom discussion." His attendance record shows only one days absence.

Ervin

Ervin has been in a class for slow learners. He has always been distractible and anxious. In addition he had a poor self-image according to the counselor's records.

He was recommended for full-time placement in a class that served the retarded educable student that was emotionally disturbed. However, his mother was reluctant to accept any full-time retarded placement and he has shown minimal gains. The mobile unit staff is seeing him for therapy and referred him for tutoring provided by the mental retardation division. Thus the small gains seen would be attributed to these efforts. It is hoped that staff from the school and the mobile unit will be able to convince the parent of the need and develop procedures whereby joint input would be utilized in any special education placement.

Harold

Harold's behavior was very poor when he was referred to the program. He was hostile and constantly involved in fights. His father's whereabouts are unknown and he resides with his mother and sister.

The incidence of fighting has decreased. At the beginning of the school year, his teacher indicated that she was having trouble getting him to do any work and that if he was not being disruptive, he was sulking. On the report card, issued in April 1979, the teacher states, "Harold's written work has improved slightly and he is making more of an effort to do his work."

Calvin

Calvin was initially placed in a retarded trainable program. His mother was dissatisfied with this placement and he was referred for help and diagnosis. He was a loner and had to be coaxed into play activities. He was a perfectionist regarding the completion of assignments and looked forward to recognition and approval.

Calvin had been seen at other mental health institutions before coming to Lehigh. At one time, Calvin developed normally and then he stopped talking and progress declined. Psychological and psychiatric evaluations were conducted due to his severe emotional problems.

He has progressed from a retarded trainable to a retarded educable class. He has had ongoing therapy from the mobile mental health staff and they have referred him to other agencies for more extensive help. His teacher states the following on his report card issued in the fall of 1978 and spring of 1979. "Calvin continues to improve in his overall performance, academically and non-academically. However, consistent positive reenforcement is necessary in order for Calvin's motivation to continue to grow. Please continue to reenforce him" (fall 1978). "Calvin's academic skills consistently continue to show signs of improvement. However, Calvin's social-emotional skills still require close and persistent one to one individualization. In order for Calvin to become completely successful, he must become more independent. Please continue to reenforce this type of behavior" (spring 1979).

Glynn

Glynn lived with his maternal grandmother until recently. He is now with his parents. He has always been a bright child but disruptive. He feels "his way" is best and he thrives on constant attention. He had a reputation of talking back to the teacher and testing authority. He has always functioned on grade level.

On his report card, this spring, his teacher writes: "Glynn is an inquisitive child. He is doing well in Math and his Reading comprehension is good. He has shown much improvement; however, he must continue to be supported in improving his behavior and work habits."

Lonnie

Lonnie's lack of achievement was due to poor attendance. This case was referred to the home and school visitor who follows up on poor attenders. It seemed to be a case of apathy in the home and Lonnie is attending on a more regular basis. His classwork is thus improving.

There are eight siblings. His mother, who cares for the children alone, was seen by staff from the mobile unit to help her in organization of the household.

Torrance

Torrance has been functioning below grade level. His parents were also concerned about his poor eating habits. He also has asthma.

The family received family counseling from the mobile unit staff and there are some signs of improvement with Torrance. He was recently transferred to Walton School to be placed in a class for students with emotional problems. His parents indicate that he is eating a little better, and his teacher indicates greater participation in class.

Miriam

Miriam has spent two years in kindergarten. She was described as having problems paying attention and thus is not learning. Child was reported by the mother to react in the same manner at home when mother attempts to help her with school work. Mother said that Miriam often "spaces out."

After therapy with the staff from the mobile unit, Miriam's teacher made the following report: "Miriam has really made progress this school year. She is developing the ability to take care of herself. She tries very hard and is paying attention to the teacher."

Robin

Robin's surrogate mother had expressed concern about Robin's poor school achievement and was invited by the school counselor to talk to the mobile mental health staff.

Robin's guardian did not always keep appointments however, and she received a termination notice from Ms. Bruce of the mobile mental health staff. This shocked her into returning and Robin continues to receive therapy. Robin's teacher reported this spring that Robin has shown "some small improvement in listening and following directions."

Mark

Mark's mother felt that he was not working up to his full potential. She has maintained constant contact with school personnel in an effort to give support.

Mark's teacher indicates that he still has a long way to go to work up to his potential. However he is now making fair progress.

Nikita

Nikita's teacher indicated that she was unable to conform to classroom routines in learning. She suspected a possible learning disability.

Nikita was seen by the staff from the mobile unit and also received a psychological examination. The mother and school personnel were advised that she did have a learning disability. She is beginning to conform to some classroom routines with the help of a special education itinerant teacher. As soon as special education procedures are finalized by the Board of Education, Nikita will be placed in a class for the learning disabled.

David

David's teacher had indicated that David had a problem of adjusting to the routines of school as well as exhibiting little success in learning. His mother was also protective of him.

After referral to the mobile unit staff for family counseling, his teacher made the following entry on his report card for the spring of 1979: "David has come a long way. I couldn't be prouder of him. He works well and tries his best. Continue to encourage him."

Jackie

Jackie was reported to be a very slow learner and had such a class placement. The mobile mental health staff recommended full-time retarded educable placement and tutoring.

Procedures, however, with the establishment of a child study team will have to be worked out.

Meanwhile tutoring and support has had some effect on her class work. Her teacher stated that "she is showing signs of improvement within the academic and non-academic areas. Please continue the positive reenforcement."

Herbert

Herbert was referred by the principal for constantly engaging in fights resulting in suspensions. In spite of the suspensions, the fighting continued. His teacher also described him as having poor peer relationships. He does not accept criticisms from adults. He also fights with his sister at home.

This family was referred for family therapy. Behavior modification techniques have been utilized with Herbert and there are signs of improvement in the classroom. He has had fewer suspensions. He still has a long way to go.

Antoinette

She is the sister of Herbert described above and exhibited the same type of behavior.

Since involvement in family therapy and the utilization of behavior modification, there are no suspensions and class work is improving.

Kenard

Kenard's mother is concerned about his behavior. She reported that previous teachers described him as having a behavior problem. The current teacher felt he had more ability than he was using. He was described as having a low frustration point. Mother stated that when Kenard became frustrated, she became frustrated. Kenard was therefore referred to the mobile mental health program.

The teacher stated on his last report that Kenard is doing nicely in mathematics and reading. His written expression and handwriting are very nice. His behavior shows some signs of improvement. He needs a great deal of reenforcement.

Brian

Brian's parents had just separated before his referral to the mobile unit. Mother had reported to the counselor that she noticed a change in Brian's behavior after the separation. He was affected more than his younger brother. His teacher felt that he was not working up to his full potential.

After referral to the mobile mental health program, Brian has made some improvement in his behavior. He has been involved in after-school sports, and has become attached to the physical education teacher who is a male and probably serves as a substitute father.

Keith

Excerpts from Keith's counseling record indicated that Keith exhibited behavioral problems since he was enrolled in school. He had difficulty relating to children and adults in the school environment as well as at home.

His teacher described him as having an explosive temper and that he battles physically and verbally with his classmates.

On his report card this spring, his teacher states that Keith is trying to do his work, however, he is still easily distracted. She sees improvement in his personal and social skills.

Towanda

Towanda's mother stated that she did not have any previous school problems with Towanda. One day, however, something happened in the classroom, and Towanda picked up her belongings and walked out. She stated that her child had to be handled with "kid gloves." The counselor referred Towanda to the mobile mental health program.

On her last report card, the teacher states that Towanda has improved in her behavior and that her grade average has improved from a D to a C.

Maurice

Maurice was referred to the counselor by his mother who felt he was being "picked on" unfairly.

Maurice was involved in more group activities after referral to the mobile mental health program. Staff from the mobile unit also gave suggestions to the teacher in relating to Maurice.

Terri

Terri's teacher indicated poor peer relations and that she frequently argued with her classmates. Her mother indicated that Terri likes to be the boss when she is with other children, and that punishment has not been effective in changing her behavior.

Staff from the mobile mental health unit utilized behavior modification techniques and suggested that they be incorporated in the classroom. As a result, her teacher is beginning to see some improvement.

Tamiko

Tamiko's mother feels that Tamiko is not reaching her potential in school because of emotional problems. She was rebellious at home.

Since referral to the mobile unit, Tamiko has made tremendous progress. Her class average has improved from a C to a B. Her teacher reported that she is a good citizen and works hard. At times however, she works too rapidly. She needs continued help so that her careless mistakes may diminish.

Laverne

The aunt with whom Laverne resides requested help because she does not follow directions and steals.

Laverne was involved with ongoing therapy for her emotional problems and also referred to the Child Guidance Clinic. Signs of improvement such as less stealing and greater class participation are beginning to occur.

Chester

Chester's teacher indicated that he was unable to work independently. His mother felt that the death of his grandmother had an effect on him.

Chester is receiving therapy for emotional problems from the mobile unit staff. His teacher indicates signs of independent working.

Gregory

Gregory's teacher had indicated that Gregory liked to come to school but "is resistant to learning." He was also labeled as quick tempered.

His mother felt that since he had been taught to fight back when annoyed, this had affected his peer relationships and was the cause of his poor behavior. He was referred to the mobile unit.

The following response was given by Gregory's teacher on his last report:

> Gregory has become a more responsible young man. He is continuing to show signs of improvement in both academic and non-academic areas. Gregory is

> showing more of a desire and a willingness to attack and learn new work and skills. He has also reached a high level of self-control.

Darrell

The counselor's report indicated that Darrell's brother was killed a few years ago. Since then he has developed an explosive temper and cries when things do not go his way. Discipline at home has not improved his behavior.

Darrell received therapy from the mobile unit staff and is beginning to show signs of improvement. He is talented in art and some of his work has been displayed around the school. Staff from the mobile unit has been working with his teacher in helping to build Darrell's self-confidence.

Kevin

Kevin was described as a very sensitive child. He had nightmares frequently and was afraid to sleep alone. He had also expressed concern about death and dying.

Kevin also received intensive therapy from the staff of the mobile unit. He is being recommended for a class for the emotionally disturbed.

Angela

Angela's teacher had referred her to the counselor for poor behavior and learning problems. The teacher's report to the counselor stated that Angela "minds other students' business more than attending to her own. She often seeks the attention of her classmates through some form of noise, by falling out of her chair or getting up to walk around the room."

After referral to the mobile unit, her report card for this spring states, "Angela is showing nice improvement in her work and work habits. She is still annoying her classmates, but not as much as she used to."

Stephen

Stephen was referred by his teacher for constant involvement in fights with his classmates. His academic areas were indicated as progressing normally. His citizenship grades however were very poor.

On his last report, the teacher stated that his behavior had gotten better and that she hoped this would continue.

Daryl

Daryl's teacher also indicated that he was progressing at a normal rate in subject areas; however, his citizenship habits needed a great deal of improvement.

On his last report card, the teacher indicated that Daryl was an alert, responsible child. He is beginning to show signs of a more harmonious rapport with his peers.

Eddie

Eddie's teacher had reported that he did not take criticism well and did not apply himself in all areas of his work. He was reported to the counselor for poor behavior.

The spring 1979 report for Eddie states that he has shown steady improvement in his academic work; however, more self-control is still needed. She stated further that when he settles down, his work is even better.

Tasha

Tasha's teacher reported that Tasha did not use her class time wisely and was not working enough to improve her basic skills.

The mobile mental health staff utilized behavior modification with Tasha. Her latest report card shows that her academic average has improved from a D to a C.

Maurice

Maurice was referred for learning problems. His teacher indicated that he was a very pleasant child who worked hard, but who has shown no improvement in his academic work.

After psychological testing by the mobile mental health staff, a learning disability was discovered. He is receiving itinerant help from the special education division and will be placed eventually in a class for the learning disabled. The help that he has received to date has been reflected in his class work. His teacher indicated recently that his reading had improved especially his comprehension of story facts. His math has improved also, "It is really great to see him make progress, because he tries so hard."

Lisa

Lisa was described as a very shy student who was not working up to potential. After involvement with the mobile mental health program, a retarded educable class was recommended.

Her mother is resisting this placement and until procedures are developed to handle this type of situation, she remains in her current class. She has not made any academic progress.

Laverne

Laverne was described as a fourth grader who was doing poorly. She lived with her grandmother. She participated very little in class activities.

After psychological testing by the mobile unit, it was discovered that Laverne had a learning disability. She is now receiving help from the itinerant teacher from special education. She is beginning to participate more in class activities and show some progress.

Norman

Norman was referred for learning problems. He seemed to have little interest in his work and the incidents of poor behavior were increasing when his attention on his work wavered.

After referral to the mobile unit and psychological and psychiatric testing, it was decided that Norman should remain in his present class placement. The recommendation was for the family to continue work with the counselor for direction and control since the family is not well structured. The mobile mental health staff will also reenforce the support needed.

Process Objective

Our process objective was to make the services of the Mental Health/Mental Retardation Agency more accessible for parents.

In order to determine if this objective was met, the following questionnaire was given to all of the parents referred to the mobile mental health program.

The results found in table 10 show that all of the parents or guardians indicated that the program was helpful. Of the 36 parents referred, 81 percent indicated that the program was very helpful and 19 percent indicated it to be somewhat helpful. None of the parents indicated that it was not helpful.

QUESTIONNAIRE

THE MOBILE MENTAL HEALTH PROGRAM

1. Are you familiar with the above program?
2. How did you learn about the program?
3. Was it easy for you to reach the van parked at the school?
4. Would you have been able to go to 3800 N. Broad Street, the main building for North Central MN/MR Agency Service, on a regular basis for scheduled appointments?
5. Were you able to visit the van parked at the school on a regular basis for scheduled appointments?
6. Did you find the services of the mobile mental health staff helpful?

To What Degree
(Please check)

Very Helpful	Somewhat Helpful	Not Helpful

7. Would you recommend the services of the Mobile Mental Health program to another parent? Why?

The summarized results follow.

QUESTIONNAIRE

THE MOBILE MENTAL HEALTH PROGRAM

1. Are you familiar with the above program? Yes 36 No 0

2. How did you learn about the program?

   From the school counselor 65
   From the principal 7

3. Was it easy for you to reach the van parked at the school?

   Yes 36 No 0

4. Would you have been able to go to 3800 N. Broad Street, the main building for North Central MN/MR Agency Service, on a regular basis for scheduled appointments?

   Yes 12 No 24

5. Were you able to visit the van parked at the school on a regular basis for scheduled appointments?

   Yes 35 No 1

6. Did you find the services of the mobile mental health staff helpful?

   Yes 36

   To What Degree
   (Please check)

Very Helpful	Somewhat Helpful	Not Helpful
29	7	

7. Would you recommend the services of the Mobile Mental Health program to another parent? Yes 36

TABLE 10

ACCESSIBILITY OF THE MOBILE MENTAL HEALTH PROGRAM TO THE PARENTS OR GUARDIANS OF THE STUDENTS REFERRED

Degree of Accessibility	Number of Parents		Percentage	
	Yes	No	Yes	No
Able to reach the van parked at the school easily	36	0	100	0
Able to travel to North Central MH/MR Agency main site on Broad Street	12	24	33	67
Able to visit van on a regular basis for appointments	35	1	97	3

All of the parents, 100 percent, indicated that it was easy to reach the mobile mental health van parked at the school as shown in table 10.

In response to whether they would have been able to go to the main site of North Central Mental Health/Mental Retardation Agency for service, 33 percent of the parents or guardians indicated yes and 67 percent indicated no. However, none visited the main site on Broad Street.

Therefore we accomplished our last objective of making the services of North Central Mental Health/Mental Retardation Agency more accessible to parents.

SIGNIFICANCE OF THE PRACTICUM AND RECOMMENDATIONS FOR FURTHER USE

The mobile mental health program was successful at the Lehigh school. The staff as well as the parents of the school became more aware of the services offered by North Central Mental Health/Mental Retardation Agency. Parents who were not able to visit the agency site in securing help for their child or family, were able to receive that help at the school location.

For the first time in the School District of Philadelphia, a program was developed and implemented that brought the services of a mental health agency in a van to a school. We had bookmobiles and career mobiles but this was the first mental health mobile.

The principal of the Lehigh School shared the results of the program at his school at a district meeting for all principals. Again, other principals expressed an interest and a need for the program at their respective schools. It is an ongoing problem getting parents to follow through on referrals to mental health agencies in the inner city.

The counseling supervisor as well as the counselor from Lehigh School shared the results of the program with all counselors in the district. They too were enthusiastic about the program.

The results of the program were also shared with the district superintendent, and the assistant director of Pupil Personnel and Counseling who is responsible for all counseling service in the city. They highly recommended that the program be continued and expanded to other schools.

As a result of the positive feedback and input for the mobile mental health program, the counseling supervisor arranged for a meeting of North Central Mental Health/ Mental Retardation Agency personnel and School District to discuss the potential expansion of the program.

A meeting was held in the district superintendent's office in May of 1978. Attending the meeting were the following representatives of North Central Mental Health/ Mental Retardation Agency and the school district of Philadelphia.

- The director of the Child and Family Unit of North Central Mental Health/Mental Retardation Agency
- The social worker, psychologist, and paraprofessional assigned to the mobile unit
- The administrative assistant to the district superintendent
- The counseling supervisor

As a result of this meeting, a decision was made by the agency and school district personnel to expand the program to four additional schools in District Four. The principals who were initially interested and requested the service were consulted when school opened in September of 1978. They were still enthusiastic and receptive.

The director of the North Central Mental Health/Mental Retardation Agency, the assistant to the district superintendent and the counseling supervisor chose the following schools:

- Rhodes Middle School
- Gillespie Junior High School
- Gratz High School
- Strawberry Mansion Junior-Senior High School

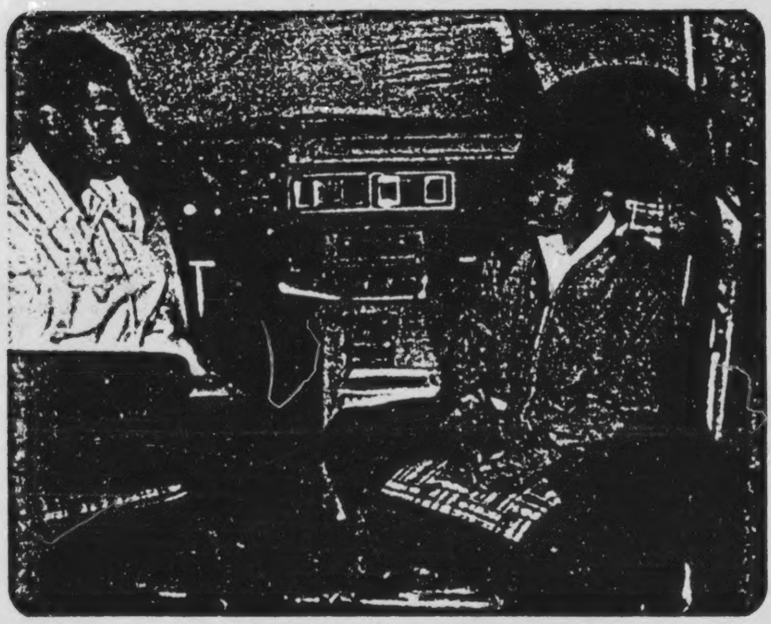
The counseling supervisor would focus on the program implemented in the above schools as Phase II of the Practicum.

Photographs of the Mobile Unit

The Mobile Unit

MOBILE UNIT

A conference with a staff member
aboard the unit



Conferences with Mrs. Bruce, supervisor
and a student with her mother

The psychologist works with a student
aboard the van

Lucky fifth

A parent with her daughter, the principal, counselor and supervisor of the mobile unit aboard the van

Phase II

Expansion of the Mobile Mental Health Program

Upon completion of Phase I, the Mobile Mental Health Program was expanded to serve four additional schools. Those schools that were chosen by a combined meeting of agency and school district personnel were:

- Rhodes Middle School
- Gillespie Junior High School
- Gratz High School
- Strawberry Mansion Junior-Senior High School

Selections were made so that there would be representation from all levels since Lehigh was an elementary site. The areas of greatest poverty were also considered in the selections.

The number of principals and counselors in the four target schools that were directly involved in the mobile program were as follows:

Target Schools

Schools	Total Number Involved	
	Principal	Counselors
Rhodes Middle	1	3
Gillespie	1	3
Gratz	1	7
Strawberry Jr.-Sr.	1	6
Total	4	19

A questionnaire was submitted to the principals and their counselors to determine their general needs. It is found in the Appendix on page 261. The responses to the questionnaire were as follows:

1. All principals and their counselors indicated a need for additional help in solving the problems and needs of their students.
2. All principals and their counselors knew of the existence of the mobile program but did not know the procedural guidelines.
3. All principals and their counselors expressed a need for orientation and written guidelines in implementing the program.
4. All of the principals and their counselors felt that the mobile program could help to serve the special needs of students who may be handicapped especially in the area of assessment.
5. All of the principals and their counselors expressed a need to make mental health services more accessible to students and their families.
6. All counselors indicated a need for procedural guidelines to comply with Public Law 94-142 in the referral, assessment, and placement of students referred to the mobile unit who may be handicapped.

In order to determine the specific needs, the referrals to the counselors for the fall of 1977 were examined. The results indicated the following:

Rhodes Middle School (3 Counselors)

Nature of Problem	Number of Students	Number of Students Referred to North Central MH/MR	Number of Students Whose Families Followed Through on Referral to North Central MH/MR
Disruptive behavior	78	37	4
Learning problems	129	46	5
Family problems	71	48	12

Gillespie Junior High School (3 Counselors)

Nature of Problem	Number of Students	Number of Students Referred to North Central MH/MR	Number of Students Whose Families Followed Through on Referral to North Central MH/MR
Disruptive behavior	224	48	11
Learning problems	149	36	8
Family problems	110	52	21
Personal problems (Dating, personality, clashes, etc.)	225	0	--
Other (Lateness attendance, rostering, etc.	490	0	--

Gratz High School (7 Counselors)

Nature of Problem	Number of Students	Number of Students Referred to North Central MH/MR	Number of Students Whose Families Followed Through on Referral to North Central MH/MR
Disruptive behavior	62	42	9
Learning problems	118	52	21
Family problems	28	24	3
Career guidance	980	0	--
Subject selection	1124	0	--
Rostering	418	0	--
Other (personal problems, etc.)	138	28	6

Strawberry Mansion School (6 Counselors)

Junior - Senior High

Nature of Problem	Number of Students	Number of Students Referred to North Central MH/MR	Number of Students Whose Families Followed Through on Referral to North Central MH/MR
Disruptive behavior	287	81	19
Learning problems	78	22	1
Family problems	82	47	11
Career guidance	587	0	--
Subject selection	800	0	--
Rostering	74	0	--
Other (personal problems)	32	21	9

The supervisor questioned the counselors at the four schools on why so few parents followed through on referrals to the mental health agency. They indicated that when they conferred with parents during conferences and on the need and failure to follow through, the following reasons were given:

Reason

- Lack of time because of other pressing problems such as illness in the family or illness of parent
- Lack of carfare
- No one to take care of smaller children
- Working during the day
- Did not want to leave immediate neighborhood

These results indicated that of the 535 families referred to North Central Mental Health/Mental Retardation Agency, 139 did not follow through because of one or more of the above reasons. These reasons were similar to those expressed at Lehigh School which was our pilot site.

Parents and teachers continued to indicate to the counselors an inability to solve their problems alone and therefore reenforced the need for outside help. The mobile mental health program seemed likely to meet some of these needs. The counselors were invited to observe the mobile mental health program by visiting Lehigh School on any Thursday which was the day that it visited that site. They were receptive to giving the program a trial run in their schools. Principals had the opportunity in August of 1977.

Since Public Law 94-142 was being introduced and implemented in the schools, the counselors whose principals expressed interest in the mobile mental health program were given a survey in September 1977 to determine their needs in relation to child study teams in general and the ramifications in working with agencies in general. This information would be needed in the implementation of the mobile mental health program. (See Appendix on p. 262.) An assessment of the needs of all counselors in the district regarding the child study team was needed by the counseling supervisor. Therefore the survey was administered not only to the counselors that would be participating in the mobile mental health program but to all counselors in the districts served by the supervisor at our first staff development meeting. This information was needed for possible expansion of the mobile mental health program to other schools as well as meeting the general needs of all counselors in relation to Public Law 94-142.

The results from the four schools involved in the mobile mental health program were as follows:

Results of the
COUNSELOR PERSONNEL DEVELOPMENT CHECKLIST
for the Four Target Schools

Your cooperation is being elicited in an effort to determine an appropriate personnel development strategy related to the implementation of CSET TEAMS in each school. Please mark those issues below that you personally would like to see addressed. In addition, please check the appropriate space on the following questions:

A. What is your school level?
Elementary ___
Middle 3
Jr. H.S. 6
Sr. H.S. 10

B. Are there special education programs in your school?
Yes 7 (Retarded educable at Gratz)
No 12

C. Have you had experience on multidisciplinary Evaluation Teams?
Yes 0
No 19

Check below	
19	1. The concept of multidisciplinary team approaches
19	2. The legal mandates of multidisciplinary approaches
19	3. Non-discriminatory assessment and identification
19	4. Roles and functions of team members
19	5. Referral procedures
19	6. Pre-evaluation procedures and strategies
19	7. Evaluation procedures
10	8. Role of the district review committee

Check below		
0	9.	Parent interviewing and counseling
19	10.	Data collection: CSET cumulative summary worksheet
19	11.	Data collection: CSET meeting report
0	12.	Classroom observation and consultation
19	13.	Guidelines for identification of handicap
19	14.	Interdisciplinary communication and relations, developing and maintaining an effective team
7	15.	I.E.P. development
19	16.	The counselor and due process (including agency advocate involvement)
19	17.	Utilization and integration of outside evaluations from agencies
19	18.	Least restrictive environment
0	19.	Confidentiality
19	20.	Dealing with agencies
19	21.	The developmental history
19	22.	Service options available to exceptional students
19	23.	Team record-keeping, maintenance and monitoring
19	24.	Other (please indicate) Special procedures for working with the mobile mental health unit.

Check
below

__19__ 25. Need for further training in relation to special education in general _____

The plan to meet the special needs in implementing Public Law 94-142 with the mobile mental health program was to have staff development on the child study team and to write a handbook for counselors that would give basic lines and encompass involvement of outside agencies.

The school system had planned general meetings for school principals and their staffs where the general principles of Public Law 94-142 were discussed. However, nothing on a city-wide basis was done relative to the specific guidelines needed by counselors as they worked with agencies relative to child study teams and procedural guidelines for placement.

The counseling supervisor would attempt to meet this need with the counselors at the schools utilizing the mobile mental health program and share the handbook with all counselors in the district. Counselors would eventually need specific detailed information on child study teams and procedural guidelines whether they utilized it in their buildings or worked with outside agencies.

Therefore the following objectives for Phase II were developed.

Objectives

1. By the end of the practicum, at least 50 percent of the principals and their counselors from the four target schools will be able to follow the guidelines and utilize the services of the mobile mental health program for their students
2. By the end of the practicum, we would increase by at least 10 percent the number of parents who follow through with the services of North Central MH/MR Agency from the four target schools
3. By the end of the practicum, at least 50 percent of the counselors participating in the mobile mental health program will be able to utilize a school-based child-study evaluation team in the assessment of those students referred to the mobile unit who may need special education classes
4. By the end of the practicum, at least 50 percent of the counselors from the four target schools will be able to proceed in the assessment and placement of those students referred to the mobile unit who need special education placement

Strategy

The counseling supervisor and the staff from the mobile mental health program met with the principals and their counselors. Reservations concerning participation in the program were expressed by the counselors from Strawberry Mansion Junion-Senior High School, however. They anticipated a decrease in the number of counselors due to a decrease in enrollment which was verified by the principal. With additional responsibilities due a possible curtailment in counseling service, they felt it would be impossible to add a new innovative program. However, if there was no curtailment, they would be willing to participate.

The following format was decided by the principals, counselors, counseling supervisor and agency personnel in several planning meetings.

Orientation

Session I - Introduction of the program to the new schools

- Participants
    - Principals and/or their counselors
- Purpose of the Program
- Program Design and Rationale
- Outcomes of the Lehigh Program

Session II - Operation of the Program

- Role of Participants
    - Mental Health Personnel
    - School Personnel

- Procedural Guidelines
    - Nature of services
    - Time and location of services
    - Guidelines for referral of students
    - Staff accountability and lines of authority
    - Confidentiality and parental involvement
    - Testing
    - Integration with school services and programs particularly the new Public Law 94-142

III Evaluation

Identification of the Students

Pupils would be referred to the mobile mental health by the following means:

- Observation of students by the principals, teachers, counselors, psychologists or the mobile mental health staff
- Inspection of student's school records by teachers or counselors
- Expression of concern from parents relative to the lack of academic progress or behavior of their child
- The recommendations from psychological and/or psychiatric testing by school or agency staff

Provision for Counseling Service

The counselors of the four schools would provide counseling service in individual and/or group sessions on a weekly basis. Counseling records as well as any other pertinent data will be kept by the counselor for all students referred to the mobile mental health program.

The counselor would have periodic conferences as needed with teachers and parents of the students in the program. The purpose of the conferences would be to share information and to enlist help in meeting the needs of the students and their families.

The counselor would also serve as a liaison between the mental health agency and the school staff.

Provision for Therapy by The Mobile Mental Health Staff

Staff from the mobile mental health unit would spend one day each week at the four target schools and continue to give one day to Lehigh. They would provide professional services to the students and families who utilize the program. The services would consist of:

- Observation of students
- Testing of students
- Therapy sessions to students and their families
- Collaboration with school staff on student needs

It would be crucial for personnel from the mobile mental health program to work closely with school staff as they worked together in meeting students needs.

Establishment of a Child Study Evaluation Team

A school-based multidisciplinary child study team would be established to assess and make recommendations for any student referred who may be handicapped. Public Law 94-142 mandates that all handicapped students be assessed by a multidisciplinary team [20]. Therefore the staff of the mobile unit would work with the school-based child study team in making assessments and recommendations for any handicapped students referred to them. A handbook indicating procedural guidelines conforming to Public Law 94-142 and school district guidelines would be written for the team to follow. Personnel from the division of special education would assist the supervisor in explaining the procedures in an orientation session or sessions as needed.

The concept of a multidisciplinary child study evaluation team requires a variety of professional persons who may have different kinds of information about and/or control over appropriate education programming for the handicapped child. As the handicapped child has multifaceted needs, the heterogeneity of these needs demand a multidisciplinary approach to decision making and program planning to meet the diverse needs of the child [20]. To be specific the law indicates the following in the education of the handicapped:

(d) No single procedure is used as the sole criterion for determining an appropriate educational program for a child; and

(e) the evaluation is made by a multidisciplinary team or group of persons, including one teacher or other specialist with knowledge in the area of suspected disability

(f) The child is assessed in all areas related to the suspected disability, including, where appropriate, health, vision, hearing social and emotional status, general intelligence, academic performance, communicative status, and motor abilities. [20 U.S.C. 1412 (5) (c).]

The composition of the child study team would include but not be limited to:

- the principal
- the counselor
- the nurse
- the psychologist
- representative of the mobile mental health agency serving the student as requested by the parents (in writing)
- parent (if possible)

The team would function under the direct supervision of the building principal. Specific functions of the team members would be developed for the assessment process for the handicapped student. In proceeding with assessment the team would:

1. seek permission from the parent (in writing) to conduct evaluations

2. review the results of the evaluation and interpretation by the appropriate team member
3. inform parents of the results of the evaluation
4. recommend special education programs and services if needed
    (a) individualized educational plan
    (b) due process notice to parent

In carrying out referrals to the mobile mental health agency and to the child study evaluation team, guidelines for the counselors to follow that will ensure the rights of the parent and their child and that will conform with guidelines for the handicapped will be developed. They will include:

1. the securing of permission from the parent or guardian to share information with North Central Mental Health/ Mental Retardation or any other community agency
2. the explanation of the evaluation process to the parent
3. due process procedures that guarantee parent rights

The counseling supervisor would meet with the counselors to explain these procedures and to distribute written guidelines on the same. Counselors would then explain these procedures to the parents.

Parents would participate on the child study evaluation team when possible. The counselor as well as other staff or agency members would implement the recommendations of the child-study evaluation team. If special education placement such as that for a learning disability, emotional problem or mental retardation is recommended, the principal would contact the district superintendent for placement. The counselor would inform the parent or guardian and continue to work with the staff from the mobile mental health program in providing help and support to the child and his/her parent in the placement process.

Implementation

The focus of Phase II of the practicum was to expand the successful mobile mental health program carried out at Lehigh Elementary School to four additional schools. The first objective of Phase II of the practicum was to enable at least 50 percent of the principals and their counselors from the four target schools to follow the guidelines and to be able to utilize the services of the mobile mental health program for their students.

In beginning our program therefore, the initial step was to arrange for orientation sessions for all concerned. This was carried out in the following way.

Orientation for Principals and their Counselors Participating in the Mobile Mental Health Program

The principals from the four target schools expressed a desire to the counseling supervisor that the orientation staff development be held at each school site if at all possible. It was very difficult for them to leave their schools, even for a half day. Arrangements were made, therefore, with the staff of the mobile mental health unit to visit each site and make a presentation. In addition, the principal of Strawberry Mansion expressed regret that he would not be able to participate in the program due to an anticipated loss of one counselor.

The counseling supervisor, staff from the mobile mental health unit and, when possible, the counselor from Lehigh, our pilot school, visited the target schools. They were:

Rhodes Middle School
Gillespie Junior High School
Gratz Senior High School

The orientation sessions were held during October 1978. The same presentation was made at each of the target schools. Session one addressed itself to the description of the program. Session two addressed itself to working guidelines.

At the beginning of the first orientation session in each school, a pre-orientation questionnaire was given to each counselor and their principal. The questions were as follows:

Pre-Orientation Questionnaire on the Mobile Mental Health Program

1. Have you heard of the mobile mental health program?

   yes _____ no _____

2. Do you know how it is staffed?

   yes _____ no _____

3. Do you know how it is funded?

   yes _____ no _____

4. Are you familiar with the guidelines of operation to implement the program?

   yes _____ no _____

5. Are you considering possible implementation of the program in your school?

   yes _____ no _____

   If no, please explain

As indicated by the results shown in table 11, all of the counselors and their principals had heard of the mobile unit but only 11 percent had a knowledge of the guidelines. The two counselors who had a knowledge of the guidelines had learned through communication with the counselor at Lehigh. They had contacted the counselor at Lehigh and queried her when they learned that the program was coming to their school. Most principals and counselors, however, did not know any details of the program.

TABLE 11

PRE-ORIENTATION ASSESSMENT OF PRINCIPALS AND THEIR COUNSELORS ON THE MOBILE MENTAL HEALTH PROGRAM

School	Personnel	Numbers	Awareness of the Mobile Mental Health Program	Knowledge of Guidelines to Utilize Program	Awareness of Funding and Staffing
Gillespie	Principal	1	1	0	0
	Counselors	3	3	0	0
Gratz	Principal	1	1	0	0
	Counselors	7	7	0	0
Rhodes	Principal	1	1	0	0
	Counselors	3	3	2	0
Whittier	Principal	1	1	0	0
	Counselors	1	1	0	0
	Total	18	18	2	0
	Percentage		100	11	0

Orientation

Session I

Introduction

The counseling supervisor presented the purpose and the background on the development of the mobile mental health program with Dr. Parker and Dr. Clark from North Central Mental Health/Mental Retardation Agency. Mr. Norman Pitt, a psychologist from North Central Mental Health/Mental Retardation Agency representing Dr. Clark, explained the design of the program. Materials and various handouts relating to mental health and the mobile program were distributed to each principal and counselor. These materials are found in the Appendix on pages 264-78.

An opportunity for questions and answers followed. The counselor from Lehigh School then gave a brief presentation on the success of the program at Lehigh School.

Operation of the Program

It was stressed by the counseling supervisor that guidelines be followed closely in implementing the program. She also added that due to the implementation of Public Law 94-142, the counselors participating in the program as well as all counselors in the district would be having staff development on the ramifications of Public Law 94-142 in working with special education students and agencies.

Each principal and counselor was given a copy of the guidelines for the mobile mental health program that were jointly developed with North Central Mental Health/Mental Retardation Agency and School District personnel such as the administrative assistant to the district superintendent, the counseling supervisor and the principal of Lehigh School.

The content and implementation of the guidelines would be discussed in Session II.

Mobile Unit Information

The North Central mobile unit is a new program of the Children and Family unit of the North Central Philadelphia Community Mental Health/Mental Retardation Center. The unit is a large van equipped with three offices inside, staffed by a team of mental health professionals. The purpose of the program is to identify and serve children and families who did not previously have knowledge of or access to Children and Family's services.

Types of Referrals

Referrals can come from various sources in the community-schools, health centers, other units within North Central, as well as walk-ins or self-referrals. Families who come into our agency have children with school problems (gang situations, family situations); adjustment problems (emotional problems of the child in reaction to temporary or severe stress); or mental retardation. The referral is screened to decide whether it is an appropriate one for the Children and Family staff. If the referral is not appropriate, we refer the persons back to the referral source for disposition, or we suggest the appropriate agency. Children and Family serves children from birth to 18 years of age, and the mental retardation component serves all ages.

Services

If the referral is an appropriate one, the next step in our process is the Intake Evaluation. We always see parents and children at the first interview. We usually ask them to bring the entire family so we can get everyone's ideas about the situation.

When the family arrives, the following stages occur in the interview:

(1) a social stage in which the therapist meets and chats with the family;

(2) a problem stage in which the inquiry is about the presenting problem;

(3) an interaction stage in which the family members are asked to talk with each other; and

(4) a goal-setting stage where the family is asked to specify just what changes they seek

The interview ends by setting an appointment for the next time, with the whole family or with some part of it.

At the second session a plan for reaching the goals is made by the family and therapist, usually involving eight family sessions, once a week on the mobile unit. The sessions are used to problem-solve, finding different ways that the family can use their strengths to work towards their goals.

Services at Children and Family Unit

Some children and families need specialized evaluations or therapy, and we will set up appointments for them at the main Children and Family Unit, 3701 North Broad Street. The staff includes psychologists, psychiatrists, social workers, educational specialist, pediatrician, neurologist, speech therapist, and early childhood developmental specialists. Types of therapy available include individual, group, and family therapy.

If a special school placement is needed, the staff will recommend the proper classroom and help the parents to see that the child is enrolled in it, as well as working with the school staff to implement such placement. We can often direct people to other sources of information.

Session II: Guidelines for Implementation of the Mobile Mental Health Program

Nature of Services

The provision of services to families who have little or no access to the main building for mental health services. The unit encourages family members to seek its services in domestic problems, children's learning problems, emotional problems, and peer relationships.

Time and Location of Services

The mobile mental health unit will park at the school site and provide one half days service to each school

Referral--through School Counselor

- School staff and/or parents of students deciding to utilize the service of the mobile mental health unit would contact the school counselor. Teachers are requested to use the counseling referral form if possible which was shown in figure 3 on page 56.
- The counselor, after discussion with the principal, would screen potential candidates.
- Potential candidates would be referred to the mobile mental health unit if parental permission is granted. The counselor should utilize the following forms for referral:
  - permission of parent--see figure 5 on page 59
  - referral to the mobile unit, see figure 4 on page 58

Identification of Students

Referral to the counselor should be determined by the following means:

- Observation of students by the principal, teachers, counselor, psychologist, or mobile staff member
- Inspection of student's school records by teacher or counselor
- Expression of need by parent
- Recommendations from psychological and/or psychiatric testing

Role of Participants:

School principal:

- Provide overall leadership and responsibility for the program operating in the school

School counselor:

- Assist in the identification of potential candidates
- Conferring with parent or guardian and securing written permission
- Referral to the mobile unit
- Providing counseling and support as needed to students and their families
- Liaison with staff from the mental health agency, school staff and parents

Teachers:

- Assist in identification of potential candidates
- Referral to school counselor

- Consult with school counselor regarding progress and needs of those students referred
- Assist counselor where appropriate in implementing recommendations received from staff of the mobile unit

Mobile Mental Health Staff:

- Assist in the identification of students
- Provide therapy and testing when needed for those students referred
- To consult with the parents or guardians of those students referred
- To work with the school counselor and school staff, where appropriate, in meeting the needs of those students referred

All of the above participants will participate in a school-based multidisciplinary child study team when established in assessing the needs and making recommendations for any student referred who may be handicapped.

Public Law 94-142 mandates that all handicapped students be assessed by a multidisciplinary team [20]. Therefore the staff of the mobile unit will work with the school-based child study team in making assessments and recommendations for any handicapped student referred to them.

All counselors will exercise current guidelines pertaining to confidentiality of information regarding students and agency involvement. They are as follows:

- The school district shall not permit access to or release of education records, or personally identifiable information contained therein of students without the written consent of the parent or eligible student.
- The written consent required must be signed and dated by the parent, guardian, or the eligible student and shall include:
  - specification of the records to be disclosed
  - purpose or purposes of the disclosure
  - the party or class of parties to whom the disclosure may be made
- A record shall be maintained indicating all parties who have requested or obtained access to students records

A question and answer period followed and the following questionnaire was given to each principal and counselor at the end of the session.

Questionnaire on Orientation Sessions Relating to the Mobile Mental Health Program

1. Did you find the orientation sessions to be very helpful________, somewhat helpful_________, not helpful _______. (Please check one)
2. Will you commit yourself to using the guidelines to

implement the program

Yes _____ No _____ (Please check one)

3. Do you feel comfortable in following the guidelines in implementing the program?

Yes _____ No _____. If no, please explain.

4. Are you able to follow the guidelines to implement the program?

Yes _____ No _____. If no, please explain.

5. Please indicate any suggestions for improvement.

This questionnaire was similar to the initial questionnaire given to them and therefore provided data that could be used to verify or repudiate the attainment of the intended objective.

The results shown in table 12 indicate that all personnel except one found the orientation sessions to be very helpful. The one exception indicated the sessions to be somewhat helpful. No one indicated that the sessions were not helpful.

All of the principals and counselors indicated that they felt knowledgeable and comfortable to implement the program.

The following schedule for school visitation was developed for the mobile mental health unit.

TABLE 12

ASSESSMENT OF THE VALUE OF THE ORIENTATION SESSIONS ON THE MOBILE UNIT

Personnel	Not Helpful	Somewhat Helpful	Very Helpful	Feel Knowledgeable and Comfortable to Implement Program
Principals	0	0	4	4
Counselors	0	1	13	14
Total number	0	1	17	18
Percentage	0	6	94	100

Day of the Week	School
Monday A.M.	Rhodes Middle
Tuesday A.M.	Gratz Senior High
Tuesday P.M.	Gillespie Junior High
Thursday (all day)	Lehigh

Due to the withdrawal of Strawberry Mansion Junior-Senior High School from the program due to curtailment of counseling service, a replacement was decided. The counseling supervisor conferred with the administrative assistant to the district superintendent and Whittier Elementary School was chosen.

Whittier is a school that could greatly benefit from the services of the mobile mental health program. It is in a poverty area with families of great need. The students attending Whittier are from kindergarten to grade four. Therefore, we would be keeping in our goals of identifying younger students.

Whittier is also in proximity to Rhodes Middle, Gillespie Junior and Gratz Senior High Schools. Therefore, it would be convenient for the mobile unit to visit Whittier.

The counseling supervisor requested data from the counselor at Whittier regarding referrals to North Central Mental Health/Mental Retardation Agency for the past year. The findings were as follows:

Referrals to the Counselor at
Whittier Elementary School

For Fall of 1977

Nature of Probelm	Number of Students	Number of Students Referred to North Central MH/MR	Number of Students Whose Families Followed Through on Referral to North Central MH/MR
Disruptive behavior	24	18	2
Learning problems	18	12	0
Family problems	16	10	0

It was felt that the needs of Whittier would fit into the objectives that had been established for the target schools. The counseling supervisor and the staff from the mobile mental health program, therefore, presented the orientation staff development to the principal and counselor at Whittier. Their response to the evaluation questionnaire is included in table 12 on page 155.

The mobile mental health staff was ready to implement an expanded program. It was decided that the visitation to Whittier would be on Monday afternoons. Three full days of service which was the maximum anticipated by North Central Mental Health/Mental Retardation Agency was realized.

The Child Study Evaluation Team

Plans were made by the counseling supervisor to have staff development sessions on the concept and functioning of the child study evaluation team for the counselors working with the mental health mobile unit and other counselors working in the district. This team commonly called CSET was required by Public Law 94-142, Commonwealth of Pennsylvania Special Education Standards, and the United States District Court PARC Consent Decree of 1972. The concept of multidisciplinary approaches to serving handicapped students calls for the coordinated involvement and collaboration of a variety of helping professions who have different kinds of information about and control over the multifaceted needs of handicapped students and their families.

Traditionally, in Philadelphia, classes were available to the majority of the retarded and those with physical handicaps or speech problems. There were very few classes for emotionally disturbed or learning disabled children. There were none for the severely and profoundly mentally retarded or for most children with severe multiple handicaps. Therefore Public Law 94-142 served a broader range of handicaps than in the past.

Those counselors working with the mobile mental health program needed to know not only the concept of CSET but also how to involve the mobile mental health program in the process. Other counselors working in the district needed to learn the concept of CSET and how any outside agency would fit into the process. It was also possible that the mobile mental health program could be functioning at other schools in the district in the future.

Two staff development sessions were held for all of the counselors in the district relating to the Child Study Evaluation Team. The first session was devoted to the impact of Public Law 94-142 and the multidisciplinary concept leading to the CSET team. The second session focused on the members of the CSET team, their roles, and the involvement of outside agencies such as the mobile mental health program.

Staff Development #1

The first session was held in School District Four on

November 6, 1978. It proceeded in the following manner.

Each counselor was given a questionnaire as they signed in. The purpose of the questionnaire was to determine how much the counselors knew of CSET and the multidisciplinary concept and to also assess their needs. The questionnaire distributed indicating the responses for the four target schools follows.

Our program and agenda for the meeting also follows.

Special Education Needs Assessment
for Counselors

November 6, 1978

To The Counselor:

The current laws of the United States and of the State of Pennsylvania, as well as court orders require the immediate implementation of PL 94-142. All staff members will be required to carry out the mandates of this law.

The purpose of this questionnaire is to find out how much knowledge of and experience with exceptional children you have, so that appropriate staff development programs can be planned. In addition, this questionnaire will give you the opportunity to identify possible problem areas, so that an effort can be made to provide the best educational program possible.

Do Not Place Your Name On This Questionnaire.

A. How well do you know the legal requirements for handicapped students as they relate to each of the following areas:

	I know Them In Some Detail	I know Them In General	I don't Know Them
1) Confidentiality and parental access to records	12	2	0
2) parent rights related to educational program planning	2	11	1
3) parent rights related to use of due process procedures used in resolving differences over school decisions	1	12	1
4) preparation of Individual Education Programs (IEPs)	0	12	2
5) implementation of Individual Educational Programs	0	12	2
6) review and revision of Individual Educational Programs	0	12	2
7) multidisciplinary evaluation or reevaluation	0	1	13
8) placement in the least restrictive environment	2	11	1
9) access to equal educational opportunities	1	10	3

B. Have you ever had experience utilizing the services of any of the following for your students:

Yes	No	
14	0	1. School Nurse
14	0	2. School Psychologist
2	12	3. Educational Evaluator or Instructional Advisor
14	0	4. Speech Therapist
14	0	5. Hearing Therapist
1	13	6. Vision Itinerant Teacher
2	12	7. Resource Room Teacher
1	13	8. Physical Therapist
1	13	9. Occupational Therapist
14	0	10. School Psychiatrist
7	7	11. Special Education Classroom Teacher
7	7	12. Special Education Supervisor

C. In your professional role, have you had any experience working with any of the following:

Yes	No	
14	0	1. Base Service Units for Mental Health/ Mental Retardation
5	9	2. Parent advocacy groups such as PARC
4	10	3. Independent or university related Diagnostic or Consultative Services
0	14	4. Child Study Evaluation Team
14	0	5. Community Agencies

D. In your professional role, have you had experience working with students formally identified as any of the following:

Yes	No	
14	0	1. Educable mentally retarded
2	12	2. Trainable mentally retarded
1	13	3. Severely and profoundly retarded
5	9	4. Socially and emotionally disturbed
4	10	5. Physically handicapped
5	9	6. Learning disabled
6	8	7. Hearing impaired
10	4	8. Visually impaired
14	0	9. Speech and language impaired
14	0	10. Mentally gifted

E. If you wish to make any additional comments that you did not have the opportunity to make, or if you wish to ask any questions or identify any problems not covered above, please use the space below.

Most counselors indicated that they needed staff development on the identification of exceptionalities and the procedures that they are responsible for in their placement and education.

SCHOOL DISTRICT OF PHILADELPHIA
DISTRICT FOUR

The Child Study Evaluation Team
Staff Development Program

November 6, 1978

8:30 A.M.	Sign-In - Registration Questionnaires Issued
8:45 A.M.	Introductory Remarks - Counseling Supervisor
9:00 A.M.	PL 94-142 and Multidisciplinary Approaches to Serving Exceptional Students - Mr. Stan Frand, Assistant Director, Division of Special Education
9:45 A.M.	Questions and Answers
10:15 A.M.	Coffee Break
10:30 A.M.	Videotape Presentation PL 94-142 "It Works for Children"
10:45 A.M.	Questions and Answers
11:00 A.M.	Small Group Breakouts
12:00 A.M.	Lunch
1:00 P.M.	Small Group Breakout PL 94-142 and the Multidisciplinary Concept A. Impact on counselors B. Impact on counselor working relationships with outside agencies 1. The Mobile Mental Health Agency
2:00 P.M.	Reports from Group Meeting Indicating Questions and Concerns on PL 94-142 and the Multidisciplinary Concept
2:45 P.M.	Refocus on the new role of the counselor and their working relationships with school staffs and community agencies Preview of next staff development for November 13.
3:00 P.M.	Completion of Evaluation Form and Dismissal

November 6, 1978

PLEASE COMPLETE AT END OF DAY AND DEPOSIT IN BOX

SCHOOL DISTRICT OF PHILADELPHIA

DISTRICT FOUR

Counselors Staff Development on the Child Study Evaluation Team

The major topics for today's session are listed below. Indicate in the appropriate box whether your level of competence is adequate in each of the areas of Knowledge, Planning Skills, Implementation Skills and Attitude related to each topic. Use the following rating scale to indicate your perception of your current level of competence.

1 - I know very little about this.

2 - I have a little knowledge about this but feel I need further training

3 - I have adequate knowledge about this and can perform as well as most professionals in this area.

4 - I have a better than average knowledge about this.

Please feel free to make other comments on the reverse side of this sheet.

Topics	Knowledge	Planning Skills	Implementation Skills	Attitudes
Purpose of multidisciplinary teams				
Specific roles, functions and responsibilities of each team member				
Multidisciplinary team operation procedures				
Relation of multidisciplinary assessment to multidisciplinary treatment				

The counseling supervisor convened and chaired the staff development session. Her introductory marks focused on the changing role of the counselor in Philadelphia Public Schools. Highlights of these remarks indicated that the counselor's priorities are always set by the policies and priorities of the school district. As a result of new laws and court mandates, special education will have a new thrust on the role of the counselor. Counselors will be expected to assist in the meeting of needs of children who are in special education programs and identifying those children in regular classes who should be in a special program. Even though the number of counselors has been decreased through layoffs and cutbacks, the counselor's responsibilities will be increased. Our staff development sessions will introduce the new law relating to special education to you and specifically your role and function. The objectives for these sessions will be found in your folders.

Folders compiled by the counseling supervisor and Mr. Frand were then distributed to each counselor. The counseling supervisor then formally introduced Mr. Frand who gave an overview of Public Law 94-142 and its impact on the school system. He referred to items in the folders and indicated that the new law would affect the working relationships and roles of all members of school staffs.

The objectives for the staff development sessions and articles referred to by Mr. Frand in the folders are found in the Appendix on pages 279-315.

During the morning session, questions relating to Public Law 94-142 and the multidisciplinary concept were responded to by the counseling supervisor and Mr. Frand. Questions relating to the impact on counseling and involvement of outside agencies as the mobile mental health unit were handled by the counseling supervisor. General information and specific questions on Public Law 94-142 were handled by Mr. Frand.

The counselors were overwhelmed by the implications for them. During the past year, there was involvement by counselors in a general way with special education, but nothing as specific as was presented to them today. They ventilated their frustration on the burden they would carry to the counseling supervisor. The counseling supervisor indicated that she understood their feelings, but that our role was changing and that we needed to focus our expertise on serving all children.

After lunch the counselors met in small groups. These groups were chaired by Mr. Frand and his staff from the Special Education Division. The counseling supervisor circulated among the groups assisting in the answering of questions when needed.

The small groups then reconvened to the large group and a question and answer period followed again.

The questions and concerns from the counselors from their small group breakouts as well as from the general discussions were recorded as well as the responses given. The counselors were told that they would receive a copy of the questions and answers for their working knowledge.

They were as follows:

Questions and Answers

Public Law 94-142 - Impact on Counselors

Legal Mandates

QUESTION: What are the basic requirements of these mandates?

ANSWER: The basic requirements are:

- that no handicapped child can be excluded from a public education because of disability
- that every child is entitled to a free appropriate education, regardless of the nature or severity of the handicap
- that handicapped students must not be segregated in public schools but must be educated with nonhandicapped students to the maximum extend appropriate to their needs
- that evaluation procedures be improved in order to avoid the inappropriate education that results from misclassification
- that procedures be developed so that parents and guardians can object to evaluation and placement decisions made with respect to their children
- that state or local educational agencies locate and identify unserved handicapped children
- the education program provided should be according to the individual needs of handicapped students
- school systems must bear special responsibilities such as the transportation of handicapped students to and from educational programs. Where placement in a public or private residential program is necessary, the school district has responsibility for the costs of the program, nonmedical care, room and board and transportation.

QUESTION: What is the purpose of the act?

ANSWER: The act is designed to:

- guarantee all handicapped youngsters a free appropriate public education, geared to their own unique needs,
- protect the educational rights of these children and their parents or guardians,
- help local education agencies, such as school districts, to provide such an education, and
- provide continuous checks to assure that programs for handicapped children are effective in helping them realize their

potential.

QUESTION: Why was this law needed?

ANSWER: Studies conducted before the law was passed showed that more than half the handicapped children in this country were not receiving an education appropriate to their special needs. Others reportedly were struggling in regular classrooms because their handicapping problems had gone undetected. In addition, one million had been excluded entirely from the public school system.

QUESTION: What are the major requirements of the act?

ANSWER: Each public school agency must:

- guarantee each handicapped child a public education designed just for him, at no cost to his parents or guardians,
- assure that all handicapped children who may require special education are located, identified, and evaluated so they may be taught according to their needs,
- guarantee an individualized education progran (IEP), in writing, for each and every handicapped child, designed specifically for that child, and developed jointly with the parent or guardian, and, if possible, with the handicapped child himself,
- guarantee parents who are not satisfied with their child's educational program the right to an impartial hearing to resolve any questions concerning the child's program,
- make certain that testing and evaluation materials are selected and used so they are fair to all children, regardless of race or culture. If English is not the language used at home, for example, the child has the right to be tested in the language he knows best,
- assure that handicapped children are educated in as normal a setting as possible. This means they should be placed with nonhandicapped children whenever feasible, and moved to special classes only if the nature or severity of their handicap requires this attention,

- develop inservice training programs for general and special educations and instructional, related services and support personnel who will be involved with handicapped learners.

QUESTION: What is meant by "related services"?

ANSWER: The term means transportation and such developmental, corrective and other supportive services as speech pathology and audiology, psychological services, physical and occupational therapy, and recreation, as well as medical and counseling services that are used for diagnostic and evaluative purposes. Also included are parent counseling and training.

QUESTION: What safeguards are provided for placement?

ANSWER: Parents may request a hearing if they are not happy with decisions made for their handicapped child or if school officials refuse to provide needed programs. If dissatisfied with the hearing results, parents may appeal to the state education department, and they may also carry their appeal to the state or federal courts. Additional safeguards are provided to protect the interests of the handicapped child and his or her parents. These include:

- the need for parental consent before a preplacement evaluation is made or before a child is first placed in a special program,
- providing written notice (in the parents' native language) of identification, evaluation or placement of the child in an educational program,
- appointment of a parent surrogate to make educational decisions for a handicapped child who is a ward of the state or whose natural parents are unknown or unavailable,
- the right to examine all relevant records regarding identification, evaluation and educational placement of the child.

QUESTION: What timelines have been established for implementation?

ANSWER: The law began to be implemented with the September 1977 school term. By September 1978, a free appropriate public education is to be made available to all handicapped children aged 3 through 18 and to all handicapped children aged 3 through 21 by September 1980. However, the law does not apply to the 3-to-5 and 18-to-21-year-old groups if the state does not provide regular education to these children.

QUESTION: Were priorities established?

ANSWER: Yes. Services are to be provided first to handicapped children who are not in school at all, and then to the most severely handicapped, within each disability, who are not receiving all the educational services they need.

QUESTION: Are private schools bound by the requirements of the act?

ANSWER: Yes, if children are placed in or referred to these schools by the state education department or by a local school district. These schools, in conjunction with local school districts, must insure that individualized educational programs are maintained for each child and that special education services are provided at no cost to the child's parents.

QUESTION: How can I learn more about this law?

ANSWER: Information is available from your special education director or the IEP Project office in your intermediate unit. Additional sources for special education professionals include the Pennsylvania Resources and Information Center for Special Education (PRISE), 1013 W. Ninth Ave., King of Prussia, Pa. 19406, and the regional resource center in your area: the Central Pennsylvania Special Education Resource Center, 5601 N. Front Street, Harrisburg, Pa. 17110; the Eastern Pennsylvania Regional Resources Center for Special Education, 1013 W. Ninth Ave., King of Prussia, Pa. 19406, or the Western Pennsylvania Special Education Regional Resource Center, 5347 William Flynn Highway, Route 8, Gibsonia, Pa. 15044.

QUESTION: What are the new federal legal mandates for the education of the handicapped?

ANSWER: Public Law 94-142 is the Federal Law which guarantees the right of the handicapped to a free and appropriate public education. Section 504 of the Rehabilitation Act of 1973 provides for basic civil rights for the handicapped by making illegal discrimination on the basis of handicap and complete copies of these laws are available in the Special Education Manual. Highlights follow.

QUESTION: What is Section 504 of the Rehabilitation Act?

ANSWER: In September, 1973, Congress passed a law that prohibits discrimination on the basis of physical or mental handicap in every federally assisted program or activity in the country. That law is Section 504 of the Rehabilitation Act.

Section 504 states that: "No otherwise qualified handicapped individual in the United States . . . shall, solely by reason of his handicap, be excluded from the participation in, be denied the benefits of, or be subjected to discrimination under any program or activity receiving Federal financial assistance."

In April 1977, a final Section 504 regulation was issued for all recipients of funds from HEW, including elementary and secondary schools, colleges, hospitals, social service agencies, and in some instances, doctors. The Section 504 regulation will effect fundamental changes in many facets of American life, in the actions and attitudes of institutions and individuals toward handicapped persons.

The term handicap includes such diseases or conditions as speech, hearing, visual and orthopedic impairments, cerebral palsy, epilepsy, muscular dystrophy, multiple schlerosis, cancer, diabetes, heart disease, mental retardation, emotional illness, and specific learning disabilities such as perceptual handicaps, dyslexia, minimal brain dysfunction and developmental aphasia.

QUESTION: What is meant by program accessibility under Section 504?

ANSWER: The regulation provides that programs must be accessible to handicapped persons. It does not require that every building or part of a building must be accessible but the program as a whole must be accessible. Structural changes to make the program accessible must be made only if alternatives, such as reassignment of classes or home visits, are not possible. The intent is to make all benefits or services available to handicapped persons as soon as possible. Institutions are given three years to complete structural changes to their physical plants; nonstructural changes must be made in 60 days.

In meeting the objective of program accessibility, a recipient must take care not to isolate or concentrate handicapped persons in settings away from nonhandicapped program participants.

All buildings for which site clearance has begun after June 3, 1977, must be designed and constructed to be accessible to handicapped persons from the start. The design standards of the American National Standards Institute (ANSI) can be used to determine minimal requirements for accessibility.

PRESCHOOL, ELEMENTARY AND SECONDARY, AND ADULT EDUCATION

The basic requirements are:

- That no handicapped child can be excluded from a public education because of disability; this requirement is effective immediately.
- That every handicapped child is entitled to a free appropriate education

- That handicapped students must not be segregated in public schools but must be educated with nonhandicapped students to the maximum extent appropriate to their needs.
- That evaluation procedures be improved in order to avoid the inappropriate education that results from misclassification.
- That procedural safeguards be established so parents and guardians can object to evaluation and placement decisions made with

respect to their children.

- That state or local educational agencies locate and identify unserved handicapped children.

An appropriate education can be afforded by many different methods, including use of regular classes with or without aids, depending on need; in private or public homes or institutions, or through combinations of such methods so long as handicapped and nonhandicapped students are educated together to the maximum extent possible. The result should be to provide the education program best suited to the individual needs of handicapped people.

It should be emphasized that where a handicapped student is so disruptive that education of other students in the classroom is impaired, the student can be reassigned. A common sense rule of reason applies in such cases.

The regulation provides that school systems bear special responsibilities, in some instances, for transportation of handicapped people to and from education programs. Where placement in a public or private residential program is necessary, the school district has responsibility for the costs of the program, nonmedical care, room and board, and transportation.

QUESTION: Exactly what do the terms "mainstreaming" and "least restrictive environment" mean? Are they synonymous?

ANSWER: The emphasis on mainstreaming and placement in the least restrictive environment are the result of civil rights legislation and court decisions that guarantee constitutional rights to handicapped persons. In the field of education, these legal demands resulted in the passage of Public Law 94-142, the Education for All Handicapped Children Act. This law is very specific with regard to the educational environment for handicapped pupils. It requires all states to establish:

"Procedures to assure that, to the maximum extent appropriate, handicapped children, including children in public or private institutions or other care facilities, are educated with children who are not handicapped, and that special classes, separate schooling, or other removal of handicapped children from the regular educational environment occus only when the nature or severity of the handicap is such that education in regular classes with the use of supplementary aids and services cannot be achieved satisfactorily."

The law is designed to guarantee that all children are provided with the opportunity to participate in the normal, day-to-day activities of school life. It does not mean the elimination of special education classes or the wholesale "dumping" of special education students into regular classes. The law prohibits continued dependence on segregated, self-contained, isolated special classes which result in the removal of all handicapped children from environments where they can interact with their "normal" peers.

For example, Johnny Smith, who is a trainable mentally retarded (TMR) child, has spent the past three years in a state residential school for the retarded. In this placement, Johnny had virtually no contact with a "normal" school age population. He was in a very restrictive environment. Educationally, Johnny can receive an appropriate program in a public school class for trainable mentally retarded students. By changing his placement from state residential school to special class in a public school, we are providing Johnny an opportunity to interact with normal peers in at least some school activities.

While Johnny would not interact with regular class students in academic areas or other classroom activities, he could and should be involved with them during lunch, recess and assembly activities.

Listed below, are the placement options available for handicapped students. They are listed in order from the least restrictive to the most restrictive:

- Regular Class
- Regular class in a regular school with supporting services (Resource Room, Itinerant Services)
- A school district special education program in a regular school (i.e., full-time class)
- A school district special education program in a special facility
- An intermediate unit program in a regular school
- An intermediate unit program in a special facility
- An appropriate private school program
- A state school program
- An approved out-of-state program
- An intermediate unit program of instruction in the home

Mainstreaming refers to the placement of a handicapped student into classroom activities with regular students. Such placements are made when it is determined that a handicapped student can satisfactorily function and progress in these regular class activities. The degree of involvement in regular classes (i.e., the degree of mainstreaming) will vary greatly from regular class involvement in nonacademic areas (art, music, phys. ed., etc.) with Special Education Services for academic subjects and/or vocational education to integration into regular classes for any or all academic areas (English, Social Studies, Math, etc.) and/or vocational education with only minimal Special Education support. Thus, the amount of mainstreaming, will depend on the level of functioning of a student, and the types and levels of programs/subjects available that would be appropriate.

QUESTION: What types of handicapped students can regular class teachers expect to find mainstreamed into their classes?

ANSWER: Mainstreaming into regular class programs is an option which must be made available to students who are identified as mildly to moderately educationally handicapped. Most students classified as educable mentally retarded, learning disabled, or socially and emotionally disturbed fall into the mildly handicapped range of ability. As is pointed out elsewhere in this document, mildly handicapped students have more similarities to the regular education population than differences, and can often benefit academically and socially from a mainstreaming experience.

In addition, many physically handicapped students can successfully be mainstreamed. Decisions to mainstream physically handicapped students may be determined on the physical accommodations of individual schools (ramps, elevators, bathroom facilities, etc.) rather than on more direct instructional considerations. However, federal legislation requires positive constructive changes in buildings to better accommodate the handicapped.

QUESTION: What handicapping conditions are we expected to work with?

ANSWER: Overview of handicapping conditions. While the following definitions and characteristics are helpful, especially in the early identification of handicapped students, it must be remembered that mildly handicapped students are similar in more ways to the non-handicapped population than they are different. Many of the behaviors that characterize a handicapped student are often exhibited by all persons at one time or another. It is not just the presence of behaviors that indicate a handicap. The student who is handicapped shows a continual pattern of many of the behaviors to a marked and inappropriate degree which necessitates special education programming.

QUESTION: What is meant by the term "high incidence handicap"?

ANSWER: This term refers to those handicaps which are most prevalent and includes the following categories: Learning Disabled, Educable Mentally Retarded and Social and Emotionally Disturbed. These handicaps are often milder than some of the less prevalent handicaps.

QUESTION: What are the common characteristics of a learning disabled student?

ANSWER: A learning disabled child is deficient in the acquisition of basic learning skills. Deficiencies include but are not limited to: the inability to reason, think, read, write, spell, or do mathematical calculations at a level and speed expected at his or her age. Persons who have learning disorders which are primarily the result of visual hearing, or other physical handicaps, mental retardation, emotional disturbance, or environmental disadvantage are not to be considered learning disabled. However, it is often difficult to eliminate the factors and so the experience of learning disability specialist is required to help identify the learning disabled child.

A person can be considered learning disabled only when a severe discrepancy exists between the person's ability and his or her academic achievement. A learning disabled child is generally of average or above average intellectual ability but is achieving significantly lower than his peers academically.

QUESTION: What are some characteristics generally associated with the learning disabled child?

ANSWER: A learning disabled child frequently experiences perceptual problems. He or she may reverse, omit, disarrange and distort letters, numbers and words in copying and even in speaking.

In a noisy classroom, the learning disabled child may have difficulty in making sense of what the teacher is saying because of disturbance. In reading, the student often loses his or her place due to the inability to focus on specific words and to ignore the rest of the page or other stimuli.

The learning disabled child may have difficulty in judging size, shape, direction, distance, and other spatial qualities. As a result, movement may be awkward and clumsy, handwriting and drawing will be sloppy; and routine motor tasks can be problematic.

The learning disabled child may display failure to discriminate among fine differences in speech sounds, sequencing such sounds and words properly, and the inability to associate meaning to them. The learning disabled child is emotionally vulnerable. Emotional reactions which might be considered inappropriate for a normal child are frequent among learning disabled pupils.

QUESTION: What are the common characteristics of an educable mentally retarded student?

ANSWER: The educable mentally retarded pupil will most often show slower than average intellectual development. In order for a student to be placed in an EMR program, his or her IQ must measure between 50 and 74. (Pa. state standards)

He or she will probably have difficulty generalizing concepts and making abstractions.

Conceptualization is often incomplete, inaccurate, and over-simplified.

The educable mentally retarded pupil will also display immature language usage and language development. The speech of EMR children is frequently characteristic of the speech of much younger children. Omitted endings on words, confused syntax, and a restricted vocabulary contribute to the EMR child's apparent language problems. Poor oral language development is also reflected in the limited writing abilities of these pupils.

Difficulty in organizing and executing assigned activities.

Problems in orientation; poor sense of direction.

The EMR student may appear to lack common sense and social awareness at times.

QUESTION: What are some of the common characteristics of an emotionally disturbed student?

ANSWER: An emotionally or socially disturbed pupil exhibits one or more of the following characteristics over a long period of time and to a marked degree.

- An inability to learn which cannot be explained by intellectual,
- sensory or health factors,
- an inability to build or maintain satisfactory interpersonal relationships with peers and teachers,
- inappropriate types of behavior or feelings,
- a general pervasive mood of unhappiness or depression, or
- a tendency to develop physical symptoms,
- pains or fears associated with personal or school problems.

Disciplinary reasons alone do not serve to characterize a pupil as socially or emotionally disturbed (Commonwealth of Pennsylvania Special Education Standards, 1977).

QUESTION: What is the distinction between a child who is emotionally ill and one who is emotionally disturbed?

ANSWER: A distinction is often made between persons who are emotionally disturbed and those who are emotionally ill. The former category includes persons who might be described as neurotic; the latter includes persons who are described as psychotic. The emotionally disturbed child does not typically have a loss of contact with reality, even though he or she may not have insight into or control over his or her behavior.

Ill children present much more severe disturbances, hallucinations, delusions, and communication problems and, except in rare instances, will not be found in regular classrooms. In many cases, it's a fine line that separates the emotionally disturbed neurotic from the emotionally ill psychotic just as it often is a fine line that differentiates "normal" behavior from "abnormal" behavior. Normal children at times engage in and display "abnormal" behavior; most emotionally disturbed children function and act "normally" in many situations. Compounding the problem of identifying emotionally disturbed children is the role of the subjectivity and cultural orientation of the examiner. While one person considers a given act a pathological behavior, another person may interpret it as a necessary part of life, and therefore normal. The identification of the emotionally disturbed child is a complex and tenuous activity which defies a clear-cut solution.

QUESTION: What are some of the signs to help me determine the students who have an emotional problem?

ANSWER: Emotional instability. Emotional responses to day-to-day life situations are often inappropriate and unpredictable. Explosiveness, acting-out behavior, or sullenness and withdrawn behavior are among the variety of excessive behaviors displayed.

Exhibits frequent nervous mannerisms. Nail-biting, sucking thumb or fingers, restlessness, finger tapping, muscle twitching and tics are among the nervous behaviors displayed as an expression of inner tension and anxiety.

Poor group acceptance. Emotionally disturbed children are often actively excluded by most children in games and group work. They are also frequently abused by peers, made fun of, teased and rejected.

Inability to judge and control personal behavior. Associated with instability is the emotionally disturbed child's seeming inability to control his or her impulses. They often fail to judge the consequences of their actions and as a result they have repeated conflicts with their families, classmates, teachers, and sometimes, the law.

Manipulative and outer-directed. Many emotionally disturbed children, especially adolescents, attempt to manipulate others to get out of work and to avoid responsibility for their own behavior. This includes getting phony excuses to get out of class and other such schemes. Outer-directedness refers to the tendency of these children to always have an excuse for their behavior, blaming someone or something else for their behavior, blaming someone or something else for their actions.

Exhibits inappropriate phobias. Emotionally disturbed children may develop unrealistic fears and other reactions, including psychosomatic illnesses, to situations perceived as threatening, even when such situations seem perfectly harmless to others. Encounters with animals, enclosure in an elevator, routine school tasks, and interaction with authority figures are just some of the situations which can upset an emotionally disturbed child.

QUESTION: What is meant by the term "low incidence handicap"?

ANSWER: This term refers to those handicaps which are less prevalent in the population including: Visually Impaired, Hearing Impaired, Trainable Mental Retarded and Severe and Profoundly Impaired. While students with these handicaps may not be able to participate in mainstreamed academics, some may be able to interact socially with non-handicapped students.

QUESTION: What defines a visually impaired student?

ANSWER: A visual impairment which adversely affects the educational performance. Placement in program for visually impaired is contingent upon an examination by an eye specialist and a written report of the nature and degree of the visual impairment.

QUESTION: What defines a hearing impaired student?

ANSWER: A hearing loss ranging from mild (hard of hearing) to profound (deaf), which interferes with the development of the communication process and results in failure to achieve full educational potential. A person shall be assigned to a program for the hearing impaired when the evaluation and Individualized Education Program indicate that such a program is appropriate, provided that the evaluation includes a report by an audiologist and otologist.

QUESTION: What are the most common characteristics of a TMR child?

ANSWER: A TMR child demonstrates impaired mental development which adversely affects his or her educational performance. He or she exhibits significantly impaired adaptive behavior in learning, maturation and/or social adjustment as a result of below average intellectual functioning. The degree of retardation and the level of social and academic functioning, not deviant behavior patterns, are the factors in determining the individualized program. No child shall be assigned to a TMR program unless his or her IQ score is lower than 55. (Pa. state standards.)

QUESTION: How can TMR students benefit from having contact with non-handicapped students?

ANSWER: Normalization and socialization - it is important for these children to learn skills which will assist their socialization such as greeting people with "Hello," shaking hands, learning to be quiet when someone else is talking, having "acceptable" table manners, getting along with classmates, etc. We learn by imitating others and therefore need some "normal" examples.

QUESTION: What are the most common characteristics of the Severe and Profoundly Impaired?

ANSWER: A severely or profoundly impaired student is one whose adaptive behavior is such that educational programming is directed towards increased independence in activities of daily living, simple work skills, communication, social skills and gross and fine motor skills.

QUESTION: What is the least restricted environment for these children?

ANSWER: Usually the least restrictive environment for a severely or profoundly impaired child is a self contained class in a regular school. However these children too can often interact with regular education students for lunch, recess, and assembly activities.

Resource Sheet

Developmental Characteristics of the Mentally Retarded

Degrees of mental retardation	Pre-School age 0-5 Maturation and development	School age 6-20 Training and Education	Adult 21 and over Social and vocational adequacy
Mild	Can develop social and communication skills; minimum retardation in sensorimotor areas; often not distinguished from normal until later age.	Can learn academic skills up to approximately sixth grade level by late teens. Can be guided toward social conformity. "Educable."	Can usually achieve social and vocational skills adequate to minimum self-support but may need guidance and assistance when under unusual social or economic stress.
Moderate	Can talk or learn to to communicate; poor social awareness; fair motor development; profits from training in self-help; can be managed with moderate supervision.	Can profit from training in social and occupational skills; unlikely to progress beyond second grade level in academic subjects; may learn to travel alone in familiar places.	May achieve self-maintenance in unskilled or semi-skilled work under sheltered conditions; needs supervision and guidance when under mild social or economic stress.
Severe	Poor motor development; speech is minimal; generally unable to profit from training in self-help; little or no communication skills.	Can talk or learn to communicate; can be trained in elemental health habits; profits from systematic habit training.	May contribute partially to self-maintenance under complete supervision; can develop self-protection skills to a minimal useful level in controlled environment.
Profound	Gross retardation; minimal capacity for functioning in sensorimotor areas; needs nursing care.	Some motor development present; may respond to minimum or limited training in self-help.	Some speech and speech development; may achieve very limited self-care; needs nursing care.

Source: The Problem of Mental Retardation. U.S. Department of Health, Education, and Welfare, Office of the Secretary, Secretary's Committee on Mental Retardation (Washington, D.C.: Government Printing Office, 1969).

Following the staff development session, many counselors personally talked to the counseling supervisor or called her on the telephone to express their concerns and frustrations. Again the counseling supervisor provided an opportunity for them to ventilate and focused on the changing role of the counselor in serving all students. Other counselors expressed frustration that their principals knew about the changes to be implemented and that they were just finding out their involvement.

The counseling supervisor indicated that the School District provided one week of staff development on Special Education this past summer from August 21 to August 25 for principals. These sessions were attended on a voluntary basis, therefore many principals did not attend because of vacations and other reasons. The Special Education Division was planning extensive staff development for the principals who would in turn have staff development in their schools. The counseling supervisor was providing an introduction into the process that would be implemented on a full scale basis soon. It was further explained that it was imperative that the counselors working with the mobile mental health unit from North Central Mental Health/Mental Retardation Agency be apprised of PL94-142 and its impact on the new program.

Staff from the mobile mental health unit had been made aware of the new law by their agency. However, they were invited to our second staff development session.

Staff Development #2

The second staff development session on the Child Study Evaluation Team was held on November 13, 1979. The counseling supervisor felt a need to share with the counselors some of the input given to counselors during telephone conversations subsequent to the first staff development session.

She informed all counselors of the voluntary sessions for principals on Special Education held in August, 1978. She also apprised them that intensive staff development was being planned by the School District for all principals who would then utilize special education resources for staff development for their respective staffs. Special education personnel would be visiting each school in the near future to do needs assessments and orient the staff to new procedures. It was crucial, however, for counselors in their daily involvement with students and community agencies to become apprised of the basic requirements of the law for everyday functioning until the new procedures were implemented on a system-wide basis. Up to now, special education personnel in each district office processed referrals for special education placement from the schools.

Staff development sessions for counselors, nurses, and teachers of the retarded were held in the spring of 1978. The school counselors, nurses played a small part in processing students for classes for the retarded. Referrals for placement were systematically processed by special education personnel in the district office after the initial referral was made by the counselor. Counselors and nurses were also involved in the writing of Individualized Education Programs for supportive services. However, the actual writing of the IEP was carried out by the special education teacher.

We were then ready for our second session.

After opening remarks by the counseling supervisor, Mr. William Riggar from the Division of Special Education gave a presentation on the functioning of the Child Study Evaluation Team. Questions and answers followed. A slide tape presentation reinforced and helped to clarify Mr. Riggar's presentation. Again there was an opportunity for questions and answers.

The counselors then divided into small groups to review the specific roles and responsibilities of the CSET team members particularly the counselors and community agencies. Mr. Riggar and his staff conducted the small groups. Handouts were distributed for discussion. They are found in the Appendix on pages 316 to 334 .

Counselors Staff Development Agenda

November 13, 1978

9:00 A.M. Opening Remarks

- Counseling Supervisor

9:30 Presentation--The Child Study Evaluation Team

- Mr. William Riggar, Special Education Department

9:50 Questions and Answers

10:00 Break

10:15 Slide Tape Presentation

- How the Child Study Team Works

10:30 Questions and Answers

10:45 Handouts and Small Group Breakouts

1. Roles and Responsibilities of CSET Team Members
2. Role of Outside Agencies as the Mobile Mental Health Team

11:45 Questions and Answers

12:00 Lunch

1:00 P.M. Simulated CSET Presentation

1:30 Questions and Answers

1:40 Presentation

- Procedural Safeguards in implementing CSET
  - Counseling Supervisor
  - William Riggar, Special Education

2:15 Questions and Answers

2:30 Refocus by Counseling Supervisor and Notification of a Handbook for Counselors for Implementation of CSET

Counselors at the target schools were concerned about the role of the mobile mental health unit in the Child Study Evaluation Team. The counseling supervisor had conferred with the Division of Pupil Personnel and Counseling as well as Dr. Clark and Ms. Bruce from North Central MH/MR Agency on the involvement of the mobile unit prior to the meeting.

It was explained to the counselors that the mobile unit staff would function as any other outside agency with CSET. If a student was receiving help from the mobile unit staff, the representative from the staff would be invited to participate as a team member. Input would be given regarding the agency's evaluations and recommendations. The staff member could represent the parent at team meetings if the parent so chose.

In addition, staff from the mobile unit would assist school personnel in the identification of students who were referred to them who might need special education placement.

It was decided that if any students referred to the mobile unit seemed to need special education placement, observations of the student by staff from the mobile unit might be necessary. Therefore a form was devised that could be utilized by the mobile staff or any other CSET team member if necessary. A sample observation form is found on pages 335 - 37 , in the Appendix.

At the close of the meeting, the following evaluation form was distributed.

Two counselors took minutes during the session. The counseling supervisor apprised the counselors of this and that they would receive a copy of the minutes. In addition, the counseling supervisor advised that the material presented would be incorporated in a handbook for them.

A copy of the minutes follows.

SCHOOL DISTRICT OF PHILADELPHIA

DISTRICT FOUR

EVALUATION OF STAFF DEVELOPMENT

ON

MULTIDISCIPLINARY TEAM IMPLEMENTATION

CHECK

Date: November 13, 1978

1. Have you participated in any other staff development activities this year concerning aspects of P.L. 94-142?

   ________ a) Yes ________ b) No
   If yes, please list subjects.

2. The purposes of the session was

   ________ a) clearly evident
   ________ b) not so evident
   ________ c) vague

3. The large group presentations were

   ________ a) very interesting
   ________ b) somewhat interesting
   ________ c) somewhat dull
   ________ d) very dull

4. The small group breakouts were

   ________ a) very interesting
   ________ b) somewhat interesting
   ________ c) somewhat dull
   ________ d) very dull

5. The ideas and activities presented were

   ________ a) very interesting
   ________ b) somewhat interesting
   ________ c) somewhat dull
   ________ d) very dull

6. I found the information presented to be

________ a) very applicable
________ b) difficult to apply
________ c) not applicable

7. What have you gained from your participation in this staff development program? (You may wish to elaborate after appropriate response.)

________ a) knowledge
________ b) planning skills
________ c) implementation skills
________ d) changed attitudes
________ e) nothing gained

8. My attendance at this session should prove ____________ in developing appropriate programs for handicapped children.

________ a) very helpful
________ b) moderately helpful
________ c) no help

9. Can you think of any suggestions for future staff development programs that might better help you in implementing programs for the handicapped students in your school?

________ a) Yes
________ b) No
________ c) Don't know
Iv yes, what are they?

THE SCHOOL DISTRICT OF PHILADELPHIA

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MEMORANDUM

TO NAME AND OFFICE Mrs. Roberta Lee, Counselor--Walton School Mrs. Sylvia Belmont, Counselor--Dobbins Tech. High School	FILE NO. 345
	DATE 12/10/78
FROM NAME AND OFFICE Agnes W. Barksdale Counseling Supervisor	SENDER'S TELEPHONE
SUBJECT Re: District Four Counselors Meeting	

I would like to express my sincere appreciation for the excellent minutes of our meeting on November 13, 1978.

It is not easy to take minutes and be an active participant during a three hour meeting. I am always pleased for the excellent response and cooperation that I receive from District Four Counselors. It is through our joint efforts that we have continued success.

With your permission, I am sharing your minutes with all of the counselors in the District. In addition to the materials distributed at the meeting, they will have a record of the procedures explained.

FORM E 30--MEMORANDUM--SCHOOL DISTRICT OF PHILADELPHIA (JUNE 1969)

Staff development for District Four Counselors was held on Monday, November 13, 1978 in the District 4 Conference Room. Secondary counselors who could not attend the morning session participated in the afternoon with elementary counselors.

The purpose of the meeting was to explain the multidisciplinary team concept and the counselor's role.

The multidisciplinary team concept was described as "a sharing of information and professional expertise for the common good of the child." Team composition was discussed, pertinent forms were distributed and their use and importance to carrying out the team concept and procedures explained.

Multidisciplinary evaluation of handicapped students is now official school district policy. A Child Study Evaluation Team must be organized in any school which has responsibility for handicapped pupils regardless of their educational setting (i.e., pupils may be housed outside the school building but be under the school's jurisdiction). The school-based Child Study Evaluation Team has the responsibility for evaluating and re-evaluating all exceptional children. There will be a District Review Committee that will examine all recommendations from the school based team and recommend necessary changes or additional evaluations. The members of both teams were described with emphasis on the importance of the counselor's role in coordinating the work and implementing team decisions.

A discussion of Procedural Safeguards followed the case presentation. Sample forms, charts and other distributed materials were explained and questions answered. Each counselor was given background information as well as samples of the official and temporary forms they will be using to carry out the work of the school based Child Study Evaluation Team.

It is suggested that counselors become familiar with the distributed material for specific information regarding procedures.

Finally, it was suggested that counselor document the time spent on special education and send to Mrs. Barksdale. This information would be helpful in DPP&C efforts to obtain additional counselors and/or aides.

Staff Development--November 13, 1978

Topics:

- I. Multidisciplinary Teams
  - A. School team--also known as Child Study Evaluation Team
  - B. District team
- II. Procedural Safeguards

School Multidisciplinary Team

Area of responsibility

All mentally retarded pupils who are under the school's jurisdiction, regardless of instructional setting. This includes the severely and profoundly impaired (SPI), trainable-mentally retarded (TMR), educable-mentally retarded (EMR) and educable-mentally retarded-emotionally disturbed (EMR-ED), all learning disabled and emotionally disturbed children.

Team composition

Principal } Co-chairpersons
Counselor }

Classroom teacher
School nurse
School psychologist
Educational diagnostician
Any other specialist who has evaluated the child (ex. hearing, speech, psychiatric, etc.)

Purpose

Re-evaluate pupils in classes for the mentally retarded
Identify, review, summarize and centralize all existing material on each mentally retarded student
Determine students' eligibility for special education programs and services and recommend courses of action

Counselor's role

Chief facilitator
Team coordinator
Responsibility for material in, and location of Child Study Evaluation Team folders
Major responsibility for implementation of team decisions
Redefinition of the counselor's role in terms of the mentally retarded student

General procedure

See Proposed Multidisciplinary Flow Chart and Outline in Handbook to be compiled and distributed

Some things to keep in mind

Every mentally retarded student must be re-evaluated every two years

The counselor chairs the team meeting, determines if there is sufficient information on each child, and assists in the implementation of team decisions. The Division of Special Education will provide technical assistance.

DPP&C has requested an evaluation aide as well as additional counselors to help with the increased workload--at this point we have no way of knowing what the outcome of these requests will be

Social workers and additional psychologists have been added to the Special Education staff

Counselors who need help with procedures and other team-related matters should contact Counseling Supervisor, Mrs. Barksdale.

Procedural Safeguards

1. No student may be evaluated without written permission of the parent or hearing officer.

2. All pertinent information regarding the student must be documented in writing for presentation to the parent.

3. Include old procedure with new procedure until all policies and procedures are available in writing.

4. Parents must be informed and read their rights at every point of decision-making.

5. Only unresolved issues go to hearing.

6. Reevaluation procedure requires notifying the parent but does not require parental signature to proceed.

7. The Individualized Education Program (IEP) for each student is written in the home school. If no diagnostician is available in the school, assistance should be requested from District Office personnel.

8. The parent, surrogate parent, or legal guardian are the only persons who can legally give written approval of the IEP. Official policy regarding foster children is unclear. Additional information should be forthcoming.

Evaluation

DATA INSTRUMENTATION

Surveys and questionnaires were the instruments used to evaluate the success of the practicum. The evaluation design was pre- and post-assessments.

Surveys and questionnaires were distributed to the participating principals and their counselors at the beginning of the orientation and staff development sessions. They were distributed again near the end of the practicum. The purpose was to assess the success of the program.

A Handbook was also compiled and given to each counselor participating in the program. It was to be used as a resource for working with Child Study Evaluation Teams. It is found in the Appendix on pages 338 - 96 . The purpose was to enable counselors to proceed in the assessment and placement of those students referred for special education placement. The Handbook was distributed in December, 1978 at the beginning of the month, to those counselors participating in the mobile mental health program. Other counselors in the district received a copy at the end of December, 1978.

Several students who needed placement in classes for the retarded at our pilot site, Lehigh School, were not placed because of the lack of clear guidelines. The School District has since developed policy; however, there were no written procedures for counselors to follow. They needed something in the interim to use as a guide until the Special Education Division of the School District printed and distributed such guidelines.

In the spring of 1979, a questionnaire was given to all of the counselors participating in the mobile mental health program. The purpose was to assess the degree to which the skills learned at the staff development sessions and the Handbook helped the counselors in working on Child Study Evaluation Teams and placing students referred to the mobile unit who needed special education placement.

The questions asked pertained to the quality of the staff development sessions, and the commitment to use the Handbook as a resource, and suggestions for improvement of the sessions.

Evaluation

Objective 1-- The first objective for Phase II of the practicum was to enable at least 50 percent of the principals and their counselors in the target schools to follow the guidelines and utilize the services of the mobile mental health program for their students.

In order to determine if this objective was met, questionnaires were given to principals and their counselors. The first questionnaire was given preceding an orientation session on the mobile unit. The second one was given at the end of the second orientation session and during the spring of 1979. The counseling supervisor also visited the four target schools to monitor progress and to respond to questions.

The results from the second questionnaire following the orientation sessions held in each school in October, 1979 on the mobile unit are shown in Table 12 on page 155.

It reflects that all of the principals and all of the counselors except one found the session to be very helpful. The one exception listed the session to be somewhat helpful. No principal or counselor indicated that the sessions were not helpful. Therefore we have a total of 100 percent of the principals and their counselors finding the sessions to be helpful. The counseling supervisor visited the target schools to follow up on the program.

On visitations, she found the procedures being followed and the program proceeding smoothly. In April, 1979, the same questionnaire was given to the principals and their counselors regarding the following of the guidelines for the mobile mental health program to utilize the services for students and their families.

The results shown in table 13 were compared to the results of the initial survey given to principals and their counselors.

On the initial survey there were not any principals and only two counselors who had a knowledge of the guidelines and able to utilize the program. This represented 11 percent.

On the post-questionnaire given to the principals and their counselors in the spring of 1979, all of the principals and their counselors had a knowledge of the guidelines and able to utilize the program. This represented 100 percent.

Objective #1 would have been met if 50 percent of the principals and their counselors would be able to follow the guidelines and utilize the services of the mobile mental health program for their students. The assessment by the questionnaires indicated 100 percent affirmative responses. Therefore our first objective was met and exceeded.

TABLE 13

COMPARISON OF PRE AND POST ASSESSMENT OF KNOWLEDGE OF THE GUIDELINES FOR IMPLEMENTATION OF THE MOBILE MENTAL HEALTH PROGRAM

			Awareness of the Mental Health Program		Knowledge of Guidelines to Utilize Program		Awareness of Funding and Staffing	
School	Personnel	No.	Pre	Post	Pre	Post	Pre	Post
Gillespie	Principal	1	1	1	0	1	0	1
	Counselors	3	3	3	0	3	0	3
Gratz	Principal	1	1	1	0	1	0	1
	Counselors	7	7	7	0	7	0	7
Rhodes	Principal	1	1	1	0	1	0	1
	Counselors	3	3	3	2	3	0	3
Whittier	Principal	1	1	1	0	1	0	1
	Counselors	1	1	1	0	1	0	1
TOTAL		18	18	18	2	18	0	18
PERCENTAGE			100	100	11	100	0	100

Obtective #2--The second objective was to increase by at least 10 percent the number of parents who followed through with the services of North Central MH/MR Agency from the four target schools.

In order to determine if this objective was met a pre and post assessment of the number of parents who followed through with the services of North Central MH/MR Agency was made.

A comparison was made of the number of parents who followed through on referrals to North Central MH/MR Agency before the mobile mental health program and after its implementation in the schools.

The results shown in table 14 indicated that for the school year, 1977-1978, 471 students were referred to North Central MH/MR Agency from the four target schools, however, only 104 families followed through on these referrals to utilize the services. This represented 22 percent of those referred.

The the school year 1978-1979, after the implementation of the mobile mental health program, 515 students were referred. Of this number 271 families followed through utilizing the mobile unit. This represented 52 percent of those referred. (These figures include Whittier and not Strawberry Mansion which was originally included.)

This represented a 30 percent increase in the percentage of families utilizing the services of the North Central MH/MR Agency. Our second objective was to increase the number of parents who followed through by 10 percent. Therefore, our second objective was obtained.

TABLE 14

COMPARISON OF THE NUMBER OF STUDENTS WHOSE FAMILIES FOLLOWED THROUGH ON REFERRALS TO NORTH CENTRAL MH/MR AGENCY BEFORE AND AFTER THE IMPLEMENTATION OF THE MOBILE PROGRAM

Target Schools	Referrals for 1977	Number of Students Whose Families Followed Through on Referrals	Referrals for 1978	Number of Students Whose Families Followed Through on Referrals
Rhodes	131	21	127	69
Gillespie	136	42	173	83
Gratz	146	39	151	78
Whittier	58	2	64	41
TOTAL	471	104	515	271
PERCENTAGE		22		52

Objective #3--The third objective was to enable at least 50 percent of the counselors participating in the mobile mental health program to be able to utilize a school-based child-study evaluation team in the assessment of those students referred to the mobile unit who may need special education classes.

In order to meet this objective, staff development sessions were held for all of the counselors in District Four. The evaluative design was a needs assessment survey given to all of the counselors. Two staff development sessions as well as a handbook were developed and implemented to meet those needs.

The needs assessment was given at the beginning of the first staff development session. The results are found on pages 162 - 64 . Most counselors felt a need for knowledge on the impact of P.L. 94-142 on them.

At the end of the second staff development session, a questionnaire evaluating the program was given to each counselor. The results were as follows.

SCHOOL DISTRICT OF PHILADELPHIA
DISTRICT FOUR
EVALUATION OF STAFF DEVELOPMENT
ON
MULTIDISCIPLINARY TEAM IMPLEMENTATION

CHECK

Date: November 13, 1978

1. Have you participated in any other staff development activities this year concerning aspects of P.L. 94-142?

   72 a) Yes   0 b) No
   If yes, please list subjects.

   P.L. 94-142 (November 6)

2. The purpose of the session was

   62 a) clearly evident
   8 b) not so evident
   2 c) vague

3. The large group presentations were

   15 a) very interesting
   52 b) somewhat interesting
   5 c) somewhat dull
   0 d) very dull

4. The small group breakouts were

   25 a) very interesting
   44 b) somewhat interesting
   3 c) somewhat dull
   0 d) very dull

5. The ideas and activities presented were
   18 a) very interesting
   52 b) somewhat interesting
   2 c) somewhat dull
   0 d) very dull

6. I found the information presented to be

45 a) very applicable
27 b) difficult to apply
0 c) not applicable

7. What have you gained from your participation in this staff development program? (You may wish to elaborate after appropriate response.)

70 a) knowledge
35 b) planning skills
33 c) implementation skills
31 d) changed attitudes
0 e) nothing gained

8. My attendance at this session should prove ____________ in developing appropriate programs for handicapped children.

48 a) very helpful
24 b) moderately helpful
0 c) no help

9. Can you think of any suggestions for future staff development programs that might better help you in implementing programs for the handicapped students in your school?

28 a) Yes
11 b) No
20 c) Don't know

10. If yes, what are they?

10. COUNSELOR COMPETENCIES NEEDED RELATING TO CSET PARTICIPATION

- Comprehensive understanding of School District Special Education policies and procedures;

- General knowledge of the characteristics of different handicapping conditions and criteria for identification as provided by State Special Education Standards;

- Knowledge of the intent and implications of PL 94-142, PARC Consent Decree and other Federal and State legislation and Court Orders which guarantee rights to exceptional students and their parents in evaluation, placement and education programming;

- Knowledge of the operating policies and procedures of CSET including procedural safeguards, due process, confidentiality and required documentation;

- Knowledge of guidelines for conducting efficient and productive team meetings;

- Recognition of, and mutual respect for the interdependency that is necessary among disciplines in order to integrate each disciplines contribution towards a total picture of the exceptional student's needs and functioning;

- Skill in taking information from parents and/or agencies involved with the referred student, i.e. case/developmental histories, intake interview, reporting, adaptive behavior, and related information;

- Skill in communicating the student's and family's strengths and weaknesses in a proper perspective to other team members to insure logical and acceptable team recommendations;

- Knowledge of the continuum of service options needed and available to identified exceptional students;

- Knowledge of the roles, responsibilities of team members;

- Skill in counseling parents regarding the evaluation and identification process including knowledge of parent/child rights and communicating the purpose of the needed evaluations;

- Skill in communication and consultation to others in the school regarding team activities;
- Ability to know when specific diagnostic information is needed for effective decision-making regarding differential diagnosis and development of individualized program recommendations.

The intent was to incorporate the main ideas from the staff development sessions and the suggested needs from item #10 of the evaluation into a handbook. The handbook would become a resource for counselors. The counseling supervisor worked assiduously in gathering material and organizing the handbook. It was distributed in December of 1978.

In April of 1979, a questionnaire was distributed to the counselors at the four target schools. The purpose was to assess if the counselors were utilizing the skills learned at the staff development sessions and from the Handbook at the end of the school year.

The results shown in table 15 showed that all counselors utilized the staff development and Handbook skills. Therefore we had a 100 percent utilization to some degree.

In determining the degree of utilization we found that none of the counselors indicated that they rarely used, or did not use at all, the skills learned. We found that 29 percent of the counselors utilized the skills frequently and 71 percent of the counselors utilized the skills very frequently. This made a total of 100 percent of the counselors utilizing their skills.

Special education was fast becoming a priority in the school district, and the counselors were finding their staff development skills and the handbook very valuable to them.

None of the counselors indicated difficulty in functioning on the CSET teams. Table 16 shows 64 percent felt they were operating in a very effective way and 36 percent felt themselves to be somewhat effective.

Thus with all of the counselors utilizing their skills in Child Study Evaluation Teams, we had achieved our third objective.

TABLE 15

SUMMARY OF RESPONSES TO THE POST STAFF DEVELOPMENT SURVEY AND QUESTIONNAIRE DISTRIBUTED TO COUNSELORS IN APRIL OF 1979 FOLLOWING THE STAFF DEVELOPMENT SESSIONS IN THE FALL OF 1978 ON THE CSET TEAM

School	Handbook and Staff Development Training Skills Utilization		Degree of Utilization of Handbook And Training Skills			
	Yes	No	Not at all	Rarely	Frequently	Very Frequently
Gillespie	3	0	0	0	1	2
Gratz	7	0	0	0	2	5
Rhodes	3	0	0	0	1	2
Whittier	1	0	0	0	0	1
Total Number of Counselors	14	0	0	0	4	10
Percentage of Counselors	100	0	0	0	29	71

TABLE 16

POST SURVEY

NUMBER OF COUNSELORS HAVING COMPETENCY IN WORKING WITH THE CHILD STUDY EVALUATION TEAMS

Target School	Much Difficulty	Some Difficulty	Somewhat Effective	Very Effective
Gillespie	0	0	1	2
Gratz	0	0	3	4
Rhodes	0	0	1	2
Whittier	0	0	0	1
Totals	0	0	5	9
Percentage of Counselors Having Competency	0	0	36	64

Objective #4--The fourth objective was to have at least 50 percent of the counselors from the four target schools by the end of the practicum to be able to proceed in the assessment and placement of those students referred to the mobile unit who need special education placement.

The second staff development session for counselors on November 13, 1978 and the handbook addressed itself to the attainment of this objective.

At the end of the staff development session an evaluation form was distributed. The results are on pages 213-16.

At the end of April, 1979, a post practicum questionnaire was also distributed to the counselors in the four target schools to assess if they were able to proceed in the assessment and placement of those students referred to the mobile unit who needed special education placement. The questionnaire and the results shown in table 17 follow.

All of the counselors found the handbook helpful and all of the counselors felt comfortable and committed to using the Handbook in working with students who needed special education placement. With a 100 percent result, our fourth objective was obtained.

QUESTIONNAIRE ON CSET HANDBOOK AND STAFF DEVELOPMENT TRAINING SKILLS

1. Did you find the staff development session for counselors on procedural safeguards in working with the handicapped to be very helpful (14), somewhat helpful (0), not helpful (0)? (Please check one.)

2. Did you find the handbook on procedural guidelines to be very helpful (13), somewhat helpful (1), not helpful (0)? (Please check one.)

3. Do you feel comfortable in using the Handbook for the assessment and placement of students who need special education placement?

   __14__ Yes   __0__ No

   If no, please explain.

   ____

   ____

   ____

4. Will you commit yourself to using the Handbook in working with and referring students who may be handicapped for placement?

   __14__ Yes   __0__ No

5. Please indicate any comments or suggestions.

   a) Ongoing staff development on serving the handicapped.
   b) Staff development for the entire school staff on CSET.
   c) Meetings to explain CSET procedures to parents.

TABLE 17

ASSESSMENT OF SKILLS GAINED FROM THE STAFF DEVELOPMENT SESSIONS AND THE HANDBOOK FOR COUNSELORS ON PROCEDURAL SAFEGUARDS--APRIL, 1979

Counselors	Future Commitment to Use the Handbook	Feel Comfortable in Using the Handbook as a Resource	Would Like More Sessions	Suggestions for Improvement
Rhodes	3	3	3	1
Gillespie	3	3	3	0
Gratz	7	7	7	2
Whittier	1	1	1	0
Total Number of Counselors	14	14	14	4
Percentage	100	100	100	28

Suggestions

1. The need for a comprehensive book explaining district as well as school procedures on CSET.

Comment

The Counseling Supervisor explained that the Special

Education Division of the School District is working on a Special Education Manual for principals to use with their staffs. It will be quite comprehensive.

2. The need for ongoing staff development sessions in the area of exceptionalities for clarification and updating.

Comment

Such meetings will be planned by the special education division. The counseling supervisor will assist in any future meetings solely for counselors.

The endorsement and utilization of the handbook and training skills on the staff development for the CSET team and the procedural safeguards near the end of the school year were critical indicators and attested to the success of the practicum in implementing the CSET team.

Significance of Practicum and Direction For Future Use

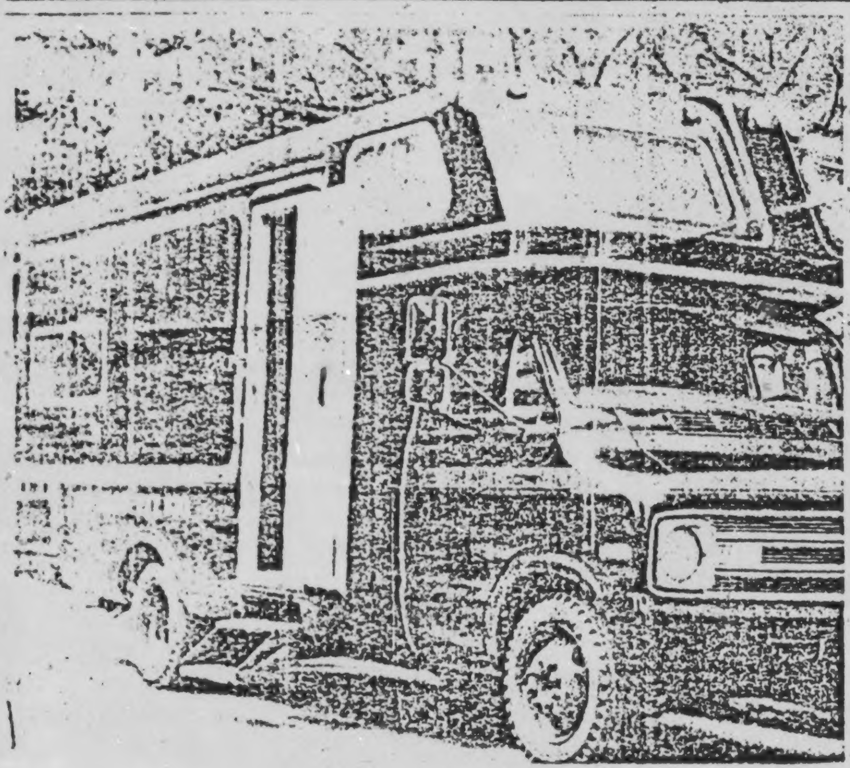
The mobile mental health program is unique in our school district. For the first time an effort has been made to bring needed mental health service to students while attending school. Students and their families did not have to travel long distances after school hours or in the evening to receive help.

We have had the book mobile and the career mobile. We now have the mental health mobile. Services that were available and not used by many families are now being utilized. The impact is enabling many families to enjoy life more as problems which did not seem to have a resolve are being dealt with. Many students have had therapy and placed in special educational settings that are enabling them to make greater progress.

The program began in one school. It has now expanded to four additional schools in the district. Other principals have expressed an interest and need, and it is possible that additional schools will be added in the future.

Already North Central Mental Health Mental Retardation Agency has seen the merit of the program and has announced evening hours for the fall. The van will park at various community sites as indicated in the following news article.

tioga news



he city's only mobile unit devoted to the emotional problems of families and children will l evening hours in the fall. The unit is a project of the North Central Philadelphia Mental alth-Mental Retardation Center, 3701 N. Broad St.

GLOSSARY

Definition of Terms

Aftercare

Services for people who have been hospitalized or other inpatient facility due to mental illness or mental retardation.

Annual Goal

The expected behavior to be achieved through the implementation of the child's individualized education program. These goals must meet the unique needs of each handicapped child as determined by appropriate assessment techniques and/or instrumentation.

Appropriately and Adequately Prepared and Trained

In the implementation of Public Law 94-142, this term means:

- Certification for all special education instructional personnel, according to State standards.

- Temporary certification, where allowable, for such personnel who do not qualify for full State certification, profided that this "temporary certification" is accompanied with an active and on-going personnel development plan.

- Certification, according to State standards, for all general (regular) education personnel serving handicapped children, plus participation in in-service education programs designed to develop skills, attitudes, and the acquisition of information specific to the needs of handicapped children.

- State-recognized certification, registration, or licensure of all support personnel, e.g., therapeutic recreation personnel, occupational therapists, itinerant resource personnel, physical therapists, diagnosticians, psychologists, counselors, aides, etc., providing direct services to handicapped children.

Assessment

All formal or informal evaluations, interviewing or testing procedures administered to a student to determine their assets and liabilities.

Base Service Unit

Another name for the community mental health/mental retardation agency that is directly responsible for making service available to the people in the City's 13 catchment areas or "communities."

Board

Stands for the Philadelphia Board of Education.

CSET

Child Study Evaluation Team of School Professionals to Assess and Plan for the Educational Program of a Student.

Community MH/MR Agency

A community agency found in all districts of the City of Philadelphia funded by the city, state and federal governments to provide mental health and mental retardation services in the community.

Consent

The granting of permission by the parent or guardian to share information about their child with an agency outside of the school.

Consent (relating to Public Law 94-142)

The parent has been fully informed in his or her native language and agrees in writing to the carrying out of the activity for which his or her consent is sought, and the consent sets forth that activity and lists the records (if any) which will be released and to whom.

Consultation and Education

Service provided by the Community MH/MR Agencies to share information and education with individuals and groups in communities in an effort to prevent mental disabilities and to promote mental health. Specialized programs for drug-dependent persons and alcoholics are also available.

Counseling Services

Activities concerned with the relationship between pupil and pupils, counselors and pupils as counselees, and between counselors and other staff members and parents for the purpose of assisting pupils to understand their educational, personal, and occupational strengths and limitations; to relate their abilities, emotions, and aptitudes to educational and career opportunities, using their abilities in formulating realistic plans; and to achieve satisfying personal and social development.

Destruction

Physical destruction or removal of personal identifiers from data so that the data is no longer personally identifiable.

Diagnosis, Evaluation

Clarify for--and with--the child, his family and other caretakers his area of achievement, his cognitive and affective assets and liabilities, interests, and learning style.

Direct Services

Services provided directly to normal or handicapped student by the state or through local educational agencies as the school.

Disruptive Behavior

Behavior or activity that disrupts the learning atmosphere in the classroom.

Dissemination

To make general and special educational instructional and support personnel, teachers, and administrators of programs for normal and handicapped children aware of significant information and promising practices derived from educational research, training, and demonstration efforts, and to train these personnel in the use of such practices with the expectation that, where appropriate, they will be implemented:

District Office

One of the eight subdivisions which, when put together, comprise the School District of Philadelphia.

District Superintendent

Administrative head of the district office who is the direct superior of principals in each district.

Early Identification

The implementation of a formal plan for identifying a handicapping condition at the earliest possible time in a child's life.

Educational Standards (relating to Public Law 94-142)

Standards for the appropriate education of a handicapped child that are specific to:

- the environment (i.e., residential, day, home-based, resource room);
- to the type and severity of the handicap

Emotionally Disturbed

A mentally ill person suffering from prolonged anxiety, depression or withdrawal or a neurosis or a psychosis. Such a person is unable to handle life's usual challenges or changes.

Emotional Problem

A problem relating to anxiety, depression, withdrawal, neurosis or psychosis making the individual unable to meet the daily routines and challenges of life.

Formal Evaluation

Evaluation, interviewing or testing procedures used selectively with an individual child excluding basic tests administered to or procedures with all children in a school.

Goal

An intent or direction to follow and is future oriented.

Goal-Setting

Determining a limited number of specific and appropriate expectations for the next steps in growth, academically and socially, consistent with the needs and goals of the total family.

Inadequate Education (according to Public Law 94-142)

Receiving some, but not all of the special education and related service specified for a handicapped child in his/her individualized educational program.

Individualized Educational Program (according to Public Law 94-142)

A special program developed to meet the particular needs of a student after diagnostic and assessment procedures by trained personnel.

Individualized Planning Conference

A meeting conducted for the purpose of developing, reviewing and/or revising a child's educational program.

In-service Training

All training other than that received in a program that leads to a degree.

Instruction

That instruction received in the classroom.

Latency Period

A period in the development of a child covering ages 6-11.

Learning Disability

A condition whereby possible minimal brain damage or dysfunction causes a deficiency in the acquisition of basic learning skills.

Least Restrictive Environment

An environment that provides the greatest interaction with non-exceptional students that a special education student can function in.

Mental Health

The way a person adjusts to life and with his/her ability to withstand the problems of life. A mentally healthy person is able to handle life's usual challenges and changes.

Mental Retardation

The inability to function normally in the cognitive area whether resulting from birth, trauma, accident, deficiency or some unknown factor.

Neurosis

A mental illness that is characterized by anxiety and not as severe as a psychosis.

Outpatient

Services for people who may benefit by visiting a therapist in regular sessions.

Paraprofessional

A person who has had some training in the area of mental health but does not have a college degree.

Parent

A parent or guardian (or individual acting as a parent in the absence of a parent or guardian) of any child on whom data is collected, maintained, or used for the purposes of identifying, locating, and evaluting children.

Partial Hospitalization

Hospitalization for people who need day, evening or weekend programs but not twenty-four-hour hospitalization.

Participating Agency

Any agency or institution which collects, maintains, data or from which data is obtained in providing service to a student and/or his/her family.

Primary Handicap

The overriding handicapping condition.

Procedure

A course of action which will be taken to implement a policy.

Psychological Services

Activities concerned with administering psychological tests and interpreting the results, gathering and interpreting information about pupil behavior, working with other staff members in planning school programs to meet the special needs of students as indicated by psychological tests and behavioral evaluations.

Psychiatrist or Psychiatric Consultant

A medical doctor that makes diagnoses and treatment for mental illnesses.

Psychosis

The name for a mental illness more serious than a neurosis.

Secondary Handicap

A handicapping condition that is not as severe as another one present.

Special Education

Specially designed instruction, at no cost to parents or guardians, to meet the unique needs of a handicapped child.

Teacher

The student's teacher or teachers, special or regular, who have a direct responsibility for implementing a student's educational program.

Therapy

Treatment given through counseling or other specialized techniques to improve mental health.

Unique Needs

Those needs identified during an individual study of a single student's learning characteristics and those factors in that student's life sphere which directly or indirectly influence changes in the students program or life.

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APPENDIX

COUNSELING FACE SHEET

CEH 132 (REV. 2/77)

PUPIL'S NAME - LAST, FIRST, MIDDLE INITIAL	BIRTH DATE - MO/DAY/YEAR

DATE OF BIRTH MO DA YR

RESIDENCE	TELEPHONE NO.	LIVES WITH	RELATIONSHIP	DATE

PUPIL'S NAME - LAST, FIRST, MIDDLE INITIAL

DATE	GR.	SCHOOL	DATE	GR.	SCHOOL

NAME OF PARENTS/GUARDIAN	CHECK IF DEC.	PLACE OF EMPLOYMENT	WORK HOURS	WORK TELEPHONE NUMBER
FATHER - FIRST, LAST				
ADDRESS				
MOTHER - FIRST, LAST				
ADDRESS				
GUARDIAN - FIRST, LAST				

CHILDREN IN FAMILY (IN ORDER OF BIRTH)	SEX	BIRTH	NAME OF SCHOOL	GR	SPECIAL INFORMATION
1					
2					
3					
4					
5					
6					
7					
8					
9					

OTHERS IN HOUSEHOLD

NAME	RELATIONSHIP	SPECIAL INFORMATION

REFERRAL INFORMATION

DATE	REFERRED BY		REASON REFERRED	REFERRED TO	
	NAME	POSITION TITLE		NAME OF COUNSELOR	NAME OF SCHOOL

DATE	SOURCE OF INFORMATION	DATE	SOURCE OF INFORMATION

OVER →

EDUCATIONAL RECORD

TEST RECORD

DATE	NAME OF TEST	SCORE

MEDICAL RECORD

DATE	

INDIVIDUAL PSYCHOLOGICAL EXAMINATIONS

DATE OF TEST	NAME OF TEST	IQ SCORE	RECOMMENDATION

COMMUNITY SERVICES

(SOCIAL AGENCIES, COMMUNITY MENTAL HEALTH CENTERS, ETC.)

DATE	SERVICE	NAME OF WORKER	TELEPHONE NUMBER

LAST NAME FIRST NAME MIDDLE NAME

PAGE No. 242

DATE

REQUEST FOR PSYCHIATRIC CONSULTANT SERVICE

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- c. 4 copies to District Superintendent (original and 3 copies)

SCHOOL Lehigh DISTRICT 4 DATE OF REQUEST 12/05/78

LAST NAME Calvin FIRST NAME INITIAL SEX M. DATE OF BIRTH / /66 PSYCHOLOGICAL DATES 11/22/74 & 6/16/78

ADDRESS ZIP NAME OF PARENTS or GUARDIAN, AGENCY & FOSTER PARENT Louis - Frances

TELEPHONE NUMBER GRADE

1. Describe the nature of the pupil's problem, considering learning, behavioral and social aspects. Include duration of problem.

   Calvin performs well in his present class setting. He has made some progress and was assigned to the present class 11/15/77. He willingly participates in work activities. This student is a loner and must be coaxed into play activities. He is withdrawn and finds it difficult to express emotions other than play. He prefers to associate with adults.
   Calvin seems to have an obsession with toy trains. He has assembled them and likes to take trains apart.

2. Describe the highlights of the pupil's development, including strengths and weaknesses.

   a. School history

      Child was placed in a slow moving class upon being entered in school. He seems to like school and is willing to accept instruction in this small group. He listens well and tries to carry out directions. He needs constant approval.

   b. Medical history

      No significant medical findings. Parent states child stopped saying words at age 1. He has a rigid walk and labored speech.

   c. Degree of independence at various age levels

      Mother gives the following information- smiled - 3 weeks; spoke words 9-10 months. Then stopped - sat alone - 9 months; dressed himself at 5 yrs.did not creep a lot but walked at 18 months.

   d. Relationships with parents and other adults, other children and siblings

      Mother states he gets along well with grandmother but is indifferent to step-grandfather. Mr. Leach. There is no father in the home. He is an only child.

Family composition and attitudes toward child including situational stresses.

4. Describe attempts to help through counseling, and other school and/or community service. What were the goals? How did the child and his family use the experience?

Mother is very cooperative and anxious to make use of any agency which will

benefit Calvin

5. List agencies known to be currently or recently active with the family. Attach written reports from agencies with a significant relationship to pupil and/or family or indicate that a request has been made for such reports to be sent to the Psychiatric Consultants.

Mrs. Wilson, Mother, has been to several agencies for evaluations because she felt something was wrong with child. At MDT she was referred back to Einstein.

1. P.G.H.
2. St. Christopher
3. Temple Mental Health
4. Einstein - requesting report to be sent to Psychiatric Consul.

6. What do you hope to gain through this consultation?

What is the proper placement for Calvin?

Signature and Title of Person who prepared material Phyllis Watson

Counselor

Signature of Principal Herbert Rogers

(additional sheets may be used for necessary information)

November 1977

SUBJECT: Calvin D.B. / /66

DATE: October 25, 1978

INTERVIEWS with CALVIN and MOTHER by PATRICIA A. CROWTHER, M.D., followed by CONFERENCE among School Personnel and Dr. Crowther-Child Psychiatrist, held at the District Four Office.

INTERVIEW WITH CALVIN:

Calvin is a physically slight 12½-year old boy who seemed extremely inhibited, withdrawn and tense. His whole body seemed overly rigid and his movements robot-like. He responded minimally and with sparse responses and he related very superficially. He seemed scared and very suspicious and on those occasions when he made eye-contact he seemed to gaze right through the interviewer. At one point in the interview he seemed to be hallucinating, turning his head back and forth as though in search of something. He smiled with bewilderment and admitted he was hearing noises, but he could not be specific and define what he heard.

He did say that he likes school. He attendes Lehigh School and is in a special class. The reason for the latter was not known. On one or more occasions he responded with appropriate but not specific responses and for at least one period he rocked.

He said he is lonely at home and claimed he and his mother live together. He seemed almost happy to be lonely and said his favorite TV show is called "Family Feud." Calvin could think of nothing positive about himself but responded to the interviewer's positive statement by reiteration.

INTERVIEW WITH MOTHER:

Despite her cooperativeness, Mrs. Wilson seemed somewhat withholding and defensive. She said she is satisfied with Calvin's present school placement but is concerned about some of his "unusual habits," such as picking up objects with two hands.

She described him as highly independent at home and said he loves to go to school. But apart from this, he shows pleasure in little else. He is socially isolated, has no friends and tends to stay inside if peers are out or go out when peers are inside. He spends much of his time with repetitive actions, reviews constantly his "gold sheets," or with information on trains. He draws endless track systems.

He has little relationship with his mother as she works from 10:00 a.m. to 5:00 p.m., six days a week.

Calvin is an only child. Pregnancy and labor were uneventful and his birthweight was 6 lbs., 2½ ozs. He was a good baby and developed much as expected during the first year. Then he developed much slower than expected. Mrs. Wilson took him to Philadelphia General Hospital, then to St. Christopher's Hospital, and said she never did get any satisfaction as to what his problem was.

He has been involved in therapy at Einstein Mental Health Center, but his mother felt "they did not help him to open up."

Mrs. Wilson said Calvin was not able to function in regular kindergarten and was placed in the Hill School with severely retarded children. He responded better in McCleskey School and Houston School where the children were not severely impaired and he is happy in his present program.

SUBJECT: Calvin (continued): October 25, 1978

CONCLUSIONS - RECOMMENDATIONS - CONFERENCE:

The developmental history substantiates the diagnosis of mental retardation. However, Calvin showed clinical evidence today of severe deviant emotional development, with marked depression, withdrawal, inhibition, and social isolation.

Urgent psychotherapy is essential if he is to profit from any school placement. His mother agreed to attend a Community Mental Health Clinic (North Central), but will need the school counselor's support.

Patricia A. Crowther

Patricia A. Crowther, M.D.
Director, Psychiatric Services

PAC/ank

CC: Mr. Lawrence-A.A., Psychologist-D.S.#4, Mrs. Barksdale, PP&C
Mr. Rogers, School Counselor

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- b. 1 copy to Counseling Supervisor
- c. 4 copies to District Superintendent (original and 3 copies)

SCHOOL ______ DISTRICT 4 DATE OF REQUEST 9/28/78

	Norman			/69	6/13/78
LAST NAME	FIRST NAME	INITIAL	SEX	DATE OF BIRTH	PSYCHOLOGICAL DATES

	19104	Tate, Guardian
ADDRESS	ZIP	NAME OF PARENTS or GUARDIAN, AGENCY & FOSTER PARENTS

None	
TELEPHONE NUMBER	GRADE

1. Describe the nature of the pupil's problem, considering learning, behavioral and social aspects. Include duration of problem.

Norman's academic learnings are more than a year below the level expected of a child his age. His attention span is short, and he is easily distracted from his work. Yet when given individual attention and constant reenforcement he is capable of successfully completing some tasks. Norman becomes a behavior problem only when his attention wavers. At those times, he may talk to a classmate sit in his seat without working, pout or cry. Socialization skills are limited.

2. Describe the highlights of the pupil's development, including strengths and weaknesses.

a. School history C A T - May 1977 - Total Battery NPR 24
Child has made normal progress - no grades repeated.
1st year teacher noted unsatisfactory progress for the entire school year and recommended a psychological. Strongest area is math.

b. Medical history
In St. Lukes Hospital at age 4 for cerebral concussion and fractured skull after being struck by auto. Large umbilical hernia repaired summer of 1978.

c. Degree of independence at various age levels
Information not available. Mother dead and he is in the care of a 76 year old grandmother and a maternal aunt.

d. Relationships with parents and other adults, other children and siblings
Extended family in the home includes a t least 8 other persons. Usually, does not a behavior problem at home. He is liked by neighborhood children.

3. Describe family composition and attitudes toward child including situational stresses.

   It has been stated that Norman becomes upset easily and shows anger when given directions. He lies and touches things that do not belong to him.

4. Describe attempts to help through counseling, and other school and/or community service. What were the goals? How did the child and his family use the experience?

   Family resistant to services

5. List agencies known to be currently or recently active with the family. Attach written reports from agencies with a significant relationship to pupil and/or family or indicate that a request has been made for such reports to be sent to the Psychiatric Consultants.

   Discussed service from M.H.Center. Grandmother and aunt did not follow through.

6. What do you hope to gain through this consultation?

   Should child be placed in R.E.Class at Lehigh.

Signature and Title of
Person who prepared material Phyllis E. Watson

Counselor

Signature of Principal Herbert Rogers, Jr.

(additional sheets may be used for necessary information)

November 1977

SUBJECT: Norman D.B. _/ /69

DATE: November 14, 1978

Lehigh School

INTERVIEWS with NORMAN and AUNT by PATRICIA A. CROWTHER, M.D., followed by CONFERENCE among School Personnel and Dr. Crowther-Child Psychiatrist, held in the District Four Office.

INTERVIEW WITH NORMAN:

Norman is a pleasant and friendly, almost 10-year old boy who seemed much younger than his years. He was initially shy but slowly related, although superficially.

He said he likes school and loves to play. He likes Leggo and Tinkertoys. He does his classwork but could not be very specific as to what this involved. He denied it gave him any trouble. He has many friends and likes his teacher. He is not a behavior problem in school.

At home Norman lives with his grandmother, an aunt, one 14-year old sister, one 13-year old brother, and a 15-year old cousin. He said his mother had died "when I was little, on Diamond Street." He remembers her and still misses her. He does not see his father.

He claimed he is the youngest at home and he likes this as the older siblings "buy me what I want." He helps with the chores, sweeps the steps, and cleans the yard, and he can come in "at any time." He said he seldom does anything with his grandmother and described himself as "a bad boy." He claimed this is because he gets mad "when they mess with me and then I beat them up." He has hurt his opponent, given him "a bloody nose," and he did not feel sorry for this.

INTERVIEW WITH AUNT:

Mrs. Tate seemed quite surprised when asked to talk with this interviewer and said the family is not concerned about Norman. Since he has been transferred to Lehigh School his behavior and academics have improved and he is anxious to stay in his present class.

She said at home he is sneaky, hard-headed, and will not listen, but she could not qualify what she meant. When asked about Norman's day, his aunt was quite evasive and seemed to be quite detached from the living experience. She did say that Norman can go to the store, can manage money, and that he spends much time outside. The family routine is very varied so it was almost impossible to know how Norman responds to a schedule.

Mrs. Tate said that Norman lived with his mother until her death five years ago. Little is known of this period of his life, although she did recall that prior to his mother's death he was hospitalized at St. Lukes', following being hit by a car. Details were not known. She felt Norman had been extremely upset after his mother's death and could not describe his behavior, but she said she feels he is only just "getting over it." She claimed that he had had a herniorrhaphy one year ago but had reacted little to the hospitalization. She and the family feel that Norman is now progressing in his present classroom and they do not want any further change.

SUB : Norman D.B. (continued): November 14, 1978

CONCLUSIONS - RECOMMENDATIONS - CONFERENCE:

Clinically, Norman seemed to be limited intellectually. While he seemed quite immature for his age, he had a shrewd, street-wise quality related to his living experience with older siblings.

There are indications that this is not a well-structured family with well-defined limits and controls, and in view of this Norman seemed to be functioning remarkably well.

I do not see a need for a different classroom experience at this t Both an and his family are pleased with his present placement. The ol counselor could be most helpful by working with the family around his n for guidance, direction and controls. Without these in his living situatic man cannot benefit totally from any school placement.

PAC/ank

Patricia A. Crowther, M.D.
Child Psychiatrist

CC: Mr. Lawrence-A.A., Psychologist--District #4, Mrs. Barksdale, PP&C
Mr. Rogers, Jr., Counselor

NORTH CENTRAL PHILADELPHIA COMMUNITY MENTAL HEALTH CENTER

[illegible] BUILDING • [illegible] FLOOR • [illegible] BROAD STREET • [illegible] PA 19140 • PHONE [illegible]

REFERRAL INFORMATION

NAME: Calvin ADDRESS: St. PHONE NO.:

BIRTHDATE: / /66 AGE: SEX: M GRADE:

TEACHER: SCHOOL: Lehigh

PRESENTING PROBLEM: Calvin He is a loner and must be coaxed into play activities. He is almost a perfectionist so far as completing assigned written tasks and likes constant approval and recognition from the teacher.

BRIEF FAMILY HISTORY AND CURRENT LIVING SITUATION (include no of family members, relatives, friends, living in the home) Mrs Wilson and Calvin live with Mrs Wilson's mother and stepfather. Mrs Wilson reported C. as having made what seemingly was normal progress up to a point. He stopped talking. Mrs Wilson said she never has been told what could have happened to cause this delay. [illegible] development has been seen at Temple Mental Health Clinic and Einstein.

EDUCATIONAL INFORMATION (include such information as any testing, special class placement, repeated grades, academic functioning) Calvin has had a psychological and psychiatric evaluation through the school district.

PARENTAL PERCEPTION OF THE PROBLEM: Mrs. Wilson has taken child for evaluations and copies have been requested from Einstein

SIGNATURE OF REFERRING PERSON: [illegible] E. [illegible]

Calvin

PERSONAL AND SOCIAL GROWTH*	FIRST REPORT	SECOND REPORT	THIRD REPORT	FINAL YEAR
CITIZENSHIP PRACTICES [illegible]	A	A		
WORK HABITS [illegible]	A-	A		

ACHIEVEMENT IN SCHOOL SUBJECTS*				
MATHEMATICS Key Math Test 2.8	1	1+		
ART		B		
HEALTH EDUCATION				
LANGUAGE ARTS SPEAKING	2+	2+		
READING CET level 4	1	1		
WRITTEN EXPRESSION				
SPELLING		1+		
HANDWRITING	1	1		
MUSIC		A		
PHYSICAL EDUCATION		B		
SCIENCE		C		
SOCIAL STUDIES				

* MAKE NO ENTRIES FOR GRADES [illegible] AND [illegible]. USE FORM H 101A, H 102A. IN YEAR 1 MAKE SUBJECT ENTRIES FOR MATHEMATICS, READING, SPEAKING AND HANDWRITING ONLY. OMIT SPEAKING AND HANDWRITING ON FIRST REPORT.

ENTER LEVELS IN CONTINUOUS PROGRESS PRIMARY

ENTER LEVEL [illegible] OF PREVIOUS YEAR

ATTENDANCE SUMMARIES (CUMULATIVE)

SCHOOL YEAR ENDING JUNE [illegible]	FIRST REPORT	SECOND REPORT	THIRD REPORT	TOTAL FOR YEAR
[illegible]	46	87		
DAYS ABSENT	0	2		
TIMES LATE	0	0		

DAYS OF ABSENCE FOR YEAR

[illegible]	TOTAL FOR YEAR
[illegible]	
[illegible]	
[illegible]	

TEACHER'S COMMENTS

FIRST REPORT Calvin continues to improve in his overall performance, ~~academically~~ ~~& non-academically~~. However consistent positive reinforcement is necessary in order for Calvin's motivation to continue to grow. Please continue to reinforce him.

SECOND REPORT Calvin's academic skills consistently continue to show signs of improvement. However Calvin's Social-Emotional skills still require close & consistent one to one individualization.

In order for Calvin to become completely successful, he must become more independent. Please continue to

THIRD REPORT reinforce this type of behavior.

END OF YEAR

MEDICAL EXAMINATION

DATE	DEFECTS NOT YET REPORTED AS TREATED	TREAT BEGUN	CASE CLOSED

SCHOOL DISTRICT OF PHILADELPHIA
TITLE I, E.S.E.A.
OFFICE OF FEDERAL PROGRAMS

NCP CMH MRC NORTH CENTRAL PHILADELPHIA COMMUNITY MH/MR CENTER

IEURY BUILDING • 5th FLOOR • 3701 N. BROAD STREET • PHILADELPHIA, PA. 19140 • PHONE (215) 226-5000

TURNER C. JOHNSON, JR., M.D., DIRECTOR

BACKGROUND INFORMATION SUMMARY

Mov[illegible]

4/[illegible]

Name David Age 6 Sex M.

School [illegible] Grade Re Teacher [illegible]

Source of Referral: Counselor David has had a problem adjusting to routines of school as well as exhibiting little success in learning. Recently has had a psychological evaluation and placement in an Re-class was made. He does not enjoy a good peer relationship and mother is protective of him. She feels children tease him unfairly.

Family Composition:

Name	Relationship	Age	Occ. or School
Jill SMALLEY	[illegible]	13	Dobbins
Shawn (dec.) HALL	brother	10	Rh[illegible]
David			
HERMAN McCANN	STEP-FA	38	
MRS. McCANN	MO.	36	

Pertinent Family History and Current Living Situation:

[illegible] and three children live together. Mother says child enjoys a positive relationship with step-father.

Birth and Developmental History: Normal [illegible] —
Mother States She was in an
emotional State while She was
carrying him. Mother worked during his early
years and [illegible] [illegible] [illegible] [illegible] [illegible]
was in care of [illegible] baby sitter.

Injuries, Accidents, Serious Illnesses:
Rare disease diagnosed by Dr. when a baby.
Toddler was between [illegible] and [illegible] years [illegible].
Dr said he would outgrow and apparently
he did. Was seen at Einstein Northern Div.

Current Health and Emotional Functioning: Enjoys good health
physically. Mother feels he has not
developed to his fullest potential
emotionally. Medical [illegible] shows eyes were
defect but it has been corrected two
other defects.

Educational History: Child's progress was very slow since
he entered school. Achieved is below the 6th
percentile [illegible] [illegible] CAT's and Stanford
Achievement Test. Thus a psychological was
administered. The recommendation was for [illegible]
and placement was made in 1977, [illegible]

Parental Perceptions of Problems: [illegible] is [illegible]
of child and his mother.

Impression of Interviewer:

Interviewer:

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A COMMUNITY SERVICE OF THE PHILADELPHIA GROUP MENTAL HEALTH-MENTAL RETARDATION ASSOCIATES, INC.
AFFILIATED WITH TEMPLE UNIVERSITY HEALTH SCIENCES CENTER

David

RATING SCALE

A = Excellent
B = Good
C = Fair
D = Barely acceptable
E = Unsatisfactory

PROGRESS SCALE

1 = Good progress
2 = Fair progress
3 = Limited progress
4 = No progress at this time

PERSONAL AND SOCIAL HABITS, PHYSICAL EDUCATION, AND ARTS	First Report	Second Report	Third Report	End of Year
ATTENDANCE	B	B		
PUNCTUALITY	A	A		
SOCIAL HABITS Assumes responsibility. Co-operates and obeys rules. Respects the property of self and others. Gets along well with others. Is courteous in speech and action.	B	B		
WORK HABITS Comes to class prepared. Makes good use of time and materials. Does neat and careful work. Completes assignments.	B	C		
HEALTH HABITS Follows medical advice with regard to physical defects. Keeps self, belongings, and surroundings neat and clean. Practices good health habits.	A	A		
PHYSICAL EDUCATION		C		
ART		B-		
HANDCRAFTS				
MUSIC		C		
PRACTICAL ARTS				
Science		C		

BASIC SKILLS	First Report	Second Report	Third Report	End of Year
HEALTH AND SAFETY				
CITIZENSHIP	1+	1		
FAMILY LIVING				
OCCUPATIONAL EDUCATION				
MATHEMATICS	2	2		
LANGUAGE ARTS				
SPEAKING				
READING	1+	1+		
WRITTEN EXPRESSION	3	3		
SPELLING	3	3		
HANDWRITING	1	2		
LISTENING	2	2		

PARTICIPATION IN SCHOOL SERVICES

274	

MEDICAL AND DENTAL EXAMINATIONS

Health plays a vital part in your child's success. The State law requires that your child be given complete medical and dental examinations periodically either by the school physician and dentist or your private physician or dentist. After each examination, you will be notified of any physical conditions that need correction.

IT IS IMPORTANT TO YOUR CHILD THAT DEFECTS BE CORRECTED AS SOON AS POSSIBLE. These corrections should be reported to the school nurse promptly. Follow-up steps are taken by the school from time to time to learn of the progress that has been made.

Whenever you need special help with your child's health problems, you are invited to contact the school office to make an appointment with the school doctor or nurse.

255

256

TEACHER'S COMMENTS

FIRST REPORT:

Reading Level Primer

David has come a long way from last. I couldn't be more prouder of him. He works well and tries his best. Give him plenty of encouragement at home.

Sylvia Fisher

SECOND REPORT:

Reading Level Primer

David can work very well at times. He becomes easily distracted from his work. Also, he can be very childish and playful at times. Please encourage him to work harder.

K. J. Williams

THIRD REPORT:

Reading Level ....

END OF YEAR:

Reading Level ....

Assigned to Room No. ....

PERIOD	SIGNATURE OF PARENT OR GUARDIAN
First Report	Betty McCann (Hal
Second Report	Betty McCann
Third Report	

PHILADELPHIA PUBLIC SCHOOLS

PROGRESS REPORT OF

David

FOR THE SCHOOL YEAR ENDING JUNE 1979

TO THE PARENTS OR GUARDIAN:

This is a personal report concerning the growth and progress of your child who is in a class for children with special needs.

Please examine this record of progress carefully. Commend your child when the work or effort is good.

Please return this report after signing your name to show that you have examined it.

You are cordially invited to call at the school office for further information.

Michael P. Marcase

Superintendent of Schools

ROOM OR GROUP	SCHOOL	TEACHER	PRINCIPAL
106	Lehigh		H. Rogers

RECORD OF ATTENDANCE

	First Report	Second Report*	Third Report*	Total for Year
DAYS PRESENT	44	85		
DAYS ABSENT	2	5		
TIMES LATE	0	0		

*Total to date.

2[illegible]

Lateness and irregular attendance interfere with a child's progress. When your child is absent, a note giving the reason should be sent to the school.

FORM EH 9—PROGRESS REPORT, SPECIAL EDUCATION—
SCHOOL DISTRICT OF PHILA. (9/75)

NCP CMH MRC NORTH CENTRAL PHILADELPHIA COMMUNITY MH/MR CENTER

5/6/78

BEURY BUILDING • 5th FLOOR • 3701 N. BROAD STREET • PHILADELPHIA, PA. 19140 • PHONE (215) 226-5000

[illegible]

TURNER C. JOHNSON, JR., M.D., DIRECTOR

BACKGROUND INFORMATION SUMMARY

Name [illegible] ______ Age 6 years [illegible]/71 Sex F

School [illegible] Grade K A.M. Teacher Mrs Warner

[illegible]

Source of Referral: Has not shown progress in K although this is 2nd year as a K student. Child is [illegible] as having problems paying attention and [illegible] is not learning. Child reacts in the same manner at home when mo tries to help with school work. Mo noticed when child was 3-4

Family Composition:

Name	Relationship	Age	Occ. or School
Mr Alfred Glover			
Mrs Alice Glover			
Alfred, Jr	Brother	7	
[illegible]		6	
[illegible]		3	
[illegible]	Sister	13 mos.	

Pertinent Family History and Current Living Situation:

[illegible] the above [illegible]
[illegible] Father [illegible]
[illegible]
[illegible] now [illegible]
[illegible] home [illegible] yrs
[illegible] is employed [illegible]

Birth and Developmental History: Mother states she was nervous and upset during pregnancy. She said there were family problems and she and husband argued a lot. At one time Miriam's appetite was poor, but she is eating better weighed 5½ lbs at birth cried for seemingly nothing, better now

Injuries, Accidents, Serious Illnesses:

Current Health and Emotional Functioning: Child is seen at Pennsylvania Hospital Clinic [illegible] mother for family planning. Mother was present for physical 1/4/77 when child was examined. K - no defects. visual screening 20/70 20/100 both eyes. Passed audiometric

Educational History: Repeating K. Former teacher expressed concern about child not learning things expected of a K. child excellent attendance.

Parental Perceptions of Problems: Mother is concerned because child "spaces out"

Impression of Interviewer:

Interviewer:

B B

B B

1 2
B

1 1

A
B
A

ATTENDANCE SUMMARIES CUMULATIVE

45	87		
1	2		
0	0		

DAYS OF ABSENCE FOR YEAR

TEACHER'S COMMENTS

Miriam has really made progress since she has been in room 113. She is developing ability to take care of herself. She pays attention and is really making progress. Please pay special attention to her handwriting.

Miriam tries very hard and pays attention to the teacher. She is making progress.

END OF YEAR

MEDICAL EXAMINATION

DATE	DEFECTS NOTED, REFERRED, TREATED		

NCP CMH MRC NORTH CENTRAL PHILADELPHIA COMMUNITY MH/MR CENTER

[illegible] • 5th FLOOR • [illegible] N. BROAD STREET • PHILADELPHIA, PA 19140 • PHONE (215) 226-5000

[illegible] JOHNSON JR. M.D., DIRECTOR

COPY

November 3, 1978

Dear Ms. A ,

I have not heard from you since school has opened. You did not respond to my correspondence sent to you on October 17, 1978. I am assuming that you do not wish for our agency to pursue evaluations on your daughter, Robin. The case in now being terminated. If in the future you feel our services may be necessary, please feel free to contact our agency. I may be reached by calling Ba6-5000, ext 330.

Yours Truly,

Ms Inez Bruce

Ms. Inez Bruce,
Supervisor, Mobile Unit
Children and Family Unit

c.c. Ms. Watson

THE SCHOOL DISTRICT OF PHILADELPHIA

MEMORANDUM

TO — NAME AND OFFICE District Four Principals and Counselors	FILE NO.
	DATE May 4, 1978
FROM — NAME AND OFFICE Agnes W. Barksdale, Counseling Supervisor	SENDER'S TELEPHONE
SUBJECT Re: Mobile Mental Health Program	

You expressed an interest earlier this year in the new mobile mental health program conducted by North Central Mental Health/ Mental Retardation Agency. Lehigh elementary school was chosen as the pilot site. We would like to expand thekprogram, and plan it around your needs.

Please respond to the following questions and return this questionnaire to me by May 15, 1978.

1. Do you see a need for additional help from community agencies in solving the problems and needs of your students?

   Please answer Yes or No

   Principal ____________ Counselor (s) ______________

2. Are you familiar with North Central Mental Health/Mental Retardation Agency's mobile mental health program?

   Please answer Yes or No

   Principal ____________ Counselor (s) ______________

   Do you know the procedural guidelines?

   Principal ____________ Counselor (s) ______________

3. Do you have a need for orientation sessions and written guidelines on the operation of the mobile mental health program?

   Principal ____________ Counselor (s) ______________

4. How could such a program help you?

   Principal ____________ Counselor (s) ______________

5. Would you and your staff be willing to work with the staff from the mobile unit one day a week?

   Principal ____________ Counselor (s) ______________

COUNSELOR PERSONNEL DEVELOPMENT CHECKLIST

Your cooperation is being elicited in an effort to determine an appropriate personnel development strategy related to the implementation of CSET TEAMS in each school. Please mark those issues below that you personally would like to see addressed. In addition, please check the appropriate space on the following questions:

A. What is your school level?

Elementary ________
Middle ________
Jr. H. S. ________
Sr. H. S. ________

B. Are there special education programs in your school?

Yes ________ No ________

C. Have you had experience on multidisciplinary Evaluation Teams?

Yes ________ No ________

Check
Below

_____ 1. The concept of multidisciplinary team approaches

_____ 2. The legal mandates of multidisciplinary approaches

_____ 3. Non-discriminatory assessment and identification

_____ 4. Roles and functions of team members

_____ 5. Referral procedures

_____ 6. Pre-evaluation procedures and strategies

_____ 7. Evaluation procedures

_____ 8. Role of the district review committee

_____ 9. Parent interviewing and counseling

Check
Below

_____ 10. Data collection: CSET cumulative summary worksheet

_____ 11. Data collection: CSET meeting report

_____ 12. Classroom observation and consultation

_____ 13. Guidelines for identification of handicap

_____ 14. Interdisciplinary communication and relations, developing and maintaining an effective team

_____ 15. I.E.P. development

_____ 16. The counselor and due process (including agency advocate involvement)

_____ 17. Utilization and integration of outside evaluations from agencies

_____ 18. Least restrictive environment

_____ 19. Confidentiality

_____ 20. Dealing with agencies

_____ 21. The developmental history

_____ 22. Service options available to exceptional students

_____ 23. Team record-keeping, maintenance and monitoring

_____ 24. Other (please indicate):

Special procedures for working with the
mobile mental health unit.
____

_____ 25. Need for further training in relation to special education in general

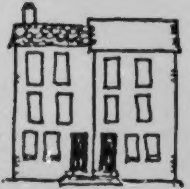
____
____

MATERIALS DISTRIBUTED TO PRINCIPALS AND THEIR COUNSELORS AT ORIENTATION SESSION I

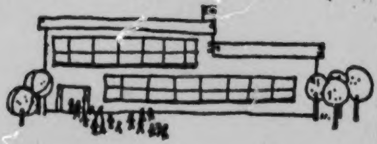
Lets get together and work on problems in our neighborhood that involve:

DRUGS

ALCOHOL



HOUSING



SCHOOLS

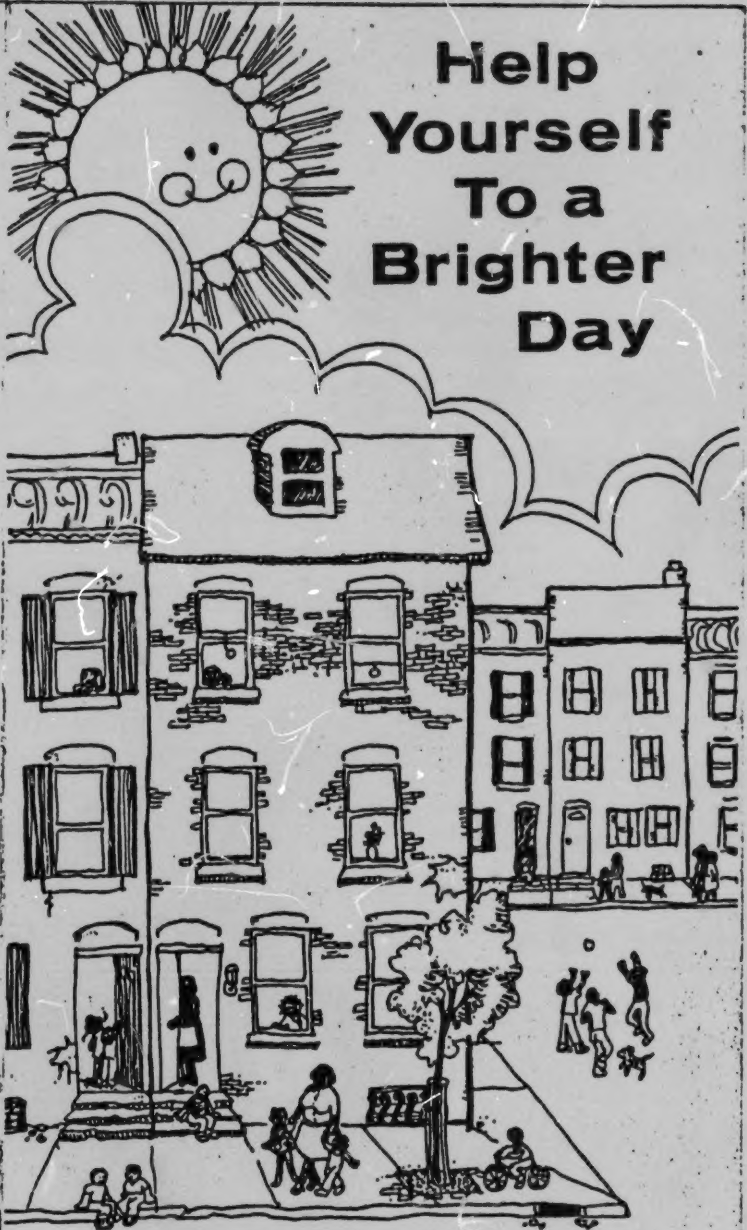
NUTRITION

EMPLOYMENT

You deserve a brighter day.

Help Yourself.

Help Yourself To a Brighter Day



COMMUNITY MENTAL HEALTH AND

MENTAL RETARDATION CENTER

[redacted]

GENERAL INFORMATION

Mental Health was recognized as a major public health problem in 1946, with the passing of the National Mental Health Act. The primary impetus for the passage of this act grew out of the disturbing reports of the nation's mental health after World War II. The purpose of the act was to provide a method of financing research and training programs; and to assist the states in establishing community mental health services.

The Mental Health Study Act passed by Congress in 1955, called for a review of the current facilities used in the study, treatment, and prevention of mental and emotional illness and in the promotion of mental and emotional health.

On February 5, 1963, President John F. Kennedy delivered to Congress a "Special Message on Mental Illness and Mental Retardation," in which he recommended a new national program for mental health and a national program to combat mental retardation. This marked the first time in history a President of the U.S. had presented a special message to Congress on these subjects.

The National Institute of Mental Health of the Public Health Service in the U.S. Department of Health, Education and Welfare is responsible for administering the program. In recent years, partly because of influence of public health thinking, professional workers in mental health have extended their concern from welfare of individual patients to populations and social groupings as well.

Under Title V of the Health Amendments Act of 1956, the National Institue of Mental Health was Authorized to provide support for mental health project grants. Legislation, passed by Congress in October 1963, provided funds for construction of comprehensive community mental health centers and of community facilities for the mentally retarded.

IT'S GOOD TO KNOW ABOUT MENTAL HEALTH

What Mental Health Is

Mental health has to do with the way a person adjusts to life, and with his ability to stay on top of it, even when the going is rough. Good mental health involves the way a person thinks, the way he acts, and his relationships with others.

Nobody is entirely worry-free. Things happen that can cause quick and sometimes chronic anger, anxiety, fear, and distrust. But the important thing is that anger and anxiety and fear and distrust should be only temporary, and not be allowed to settle in and become an habitual response to life's everyday stresses. A healthy person does not become bogged down in such feelings.

A mentally healthy person can cope with life. It isn't always easy, and is not without some struggle. But he is able to handle life's usual challenges and changes, and the different stages everyone faces in life (school, marriage, loss of loved ones, retirement).

To the emotionally disturbed or mentally ill person, the bad things are exaggerated and seen as bigger than life-size. He loses his grip. Problems that can be conquered by the healthy person become too much for him. Life has him on the run. The joys that should come with healthy living escape him. He sees life as essentially a grim experience.

Two Important Tips

If you are reasonably mentally healthy, be glad about it but don't be hard on those who may be more vulnerable.

If you have a mental or emotional problem from time to time, or over a longer period, try not to be unduly discouraged. Help can come from yourself, and from others. Very few people avoid having some symptoms of stress at some stage in life.

What to Watch For

You can help yourself and your family and friends a great deal by knowing some of the warning signs that may indicate deeper and more complex problems for which help may be needed. These signs include:

Undue, Prolonged Anxiety

This is an anxiety out of proportion to any reason or cause you can identify. Things happen, of course, which make people tense and anxious. If you see that a small child is in danger of being hit by a car for example. you would get very anxious. However, a deep, continuing anxiety, a state of constant anxiousness and fear, fastening itself upon first one "cause" and then another, is not healthy.

Depression

The kind that takes hold and usually is followed by withdrawal--withdrawal from friends normally enjoyed, from loved ones, from the usual occupations and hobbies that gave pleasure. A person suffering from depression does not seem to care or to be aware of what goes. Other symptoms are feeling bad about yourself, losing confidence, being unduly pessimistic or feeling constantly helpless.

Abrupt Changes in Mood and Behavior

Others may notice this more than the person himself. This does not include the kinds of changes a person adopts for self-improvement and considers socially desirable. That type of change can be healthy. Rather, it refers to things such as becoming depressed after a job promotion which should give pleasure. (Again, there may be some normal anxiety when facing new, demanding tasks in a better job, but the new job should be a challenge, not a horror.) Or it can refer to behavior differing from one's usual habits, and contrary to his usual way of thinking (for example, when a person very careful about money suddenly begins gambling away large sums).

Tension-Caused Physical Symptoms

These are physical ailments and complaints that have no organic cause. They may range from daily headaches or migraine induced by tension, to nausea, pains that are exaggerated, and a general attitude of medical complaints without physical basis. However, these psychosomatic symptoms, including the pain, are very real. The individual really suffers. It is well to keep in mind, too, that only a physician is qualified to determine whether a physical complaint has a physical basis or not. Medical tests may reveal an organic cause after the person himself has decided his ailment is "all in his head." Any persistent physical ailment should be checked first with a doctor.

Perfectionism

An attitude of perfectionism may mean unrealistic demands by the person upon himself, his family and friends, or his job situation. The requirement that everyone and everything, including himself, be "perfect" is an unrealistic ideal that can cause great stress to a person and his fmaily. High standards are one thing, but unreasonable expectations followed by bitter disappointment are something else. The perfectionist often lacks the generous, compassionate attitude toward himself and others that healthy living requires.

Habitually Falling Below Potential

If the person lacks the skills or orientation to reach goals in life equal to his potential, this can be corrected by training. However, if he is adequately equipped to do well but his performance continues to fall far below his usual ability, the possibility of an emotional problem should be looked into.

If any of these warning signs are severe and long-continued, professional help may be needed. If the true cause of the problem can be identified, often the symptoms are gradually cleared away.

Causes of Mental Disorders

The basic causes of mental and emotional illnesses strongly engage the attention of the medical and psychiatric professions, and the best efforts of the world's foremost research scientists. They are looking into biochemical factors, possible hereditary or genetic influences, and how what happens to people and how they view what happens to them can become contributing causes. Only by piecing together the puzzle can science arrive at the best ways to prevent or treat mental illness. The answers are not easy to come by, but the most creative and best trained scientists--of many fields and specialties--are involved in the search.

Sometimes physical problems cause behavior changes. Brain damage can do that, as can the ravages of VD, encephalitis, and other diseases.

Then heredity may be a factor, but so far its exact relationship to mental illness is not known.

More is known about environmental factors, and here much can be done for the troubled person. For example, a good environment is one in which the person can feel reasonable self-esteem. He needs to feel respected, important in the scheme of things, and valued at home, on the job, and at play.

A person whose environment fosters his self-esteem gets along well with most other people. A person who lacks it may become a harsh judge of others, come to hate himself, and project that hostility upon other people. At times the environment has to be changed, and this sometimes may be the reason for the advice, "You need a change of scenery!"

Helping Yourself to Mental Health

There are a number of simple steps that can help enormously in keeping, or achieving, good mental health. They actually are ways of making life run more smoothly and easily and well. When an individual relaxes, so can others around him; when he is cooperative and outgoing, he stimulates the cooperative spirit in others. On the other hand, a person who is fearful and tense brings forth a defensive reaction from others. Try these suggestions:

The "Easy Does It!" Approach May be Best

It means getting the job at hand done without overreacting to a challenge, or "ruffling the feathers" of other people. It implies a sure command of the situation. It means having goals, but having them in perspective and seeing them as part of a larger purpose. It means the ability to compromise with others who also have rights, but who may not see eye-to-eye on every point. It means enlisting cooperation, not arousing antagonism.

Help Others

If an individual has become moody and unable to take effective action, one sure way he can break this cycle is to try to help some one else. This is a very practical principle of living.

Try to Analyze and Handle Anger

Anger quite often results from simple frustration. For example, if at work you are put down or ignored and yet your response must be restrained, you may flare off suddenly at someone else. Knowing why you are angry and acknowledging it may help. A good way to get rid of anger and tension is by talking matters over with a sensible, trustworthy person. This may help you to think more clearly. The person to whom you talk may be a wise personal friend, a clergyman, a physician, a relative, or a professional counselor.

Don't Brood

Often a simple change of pace, or a refocusing of energies and effort, is a way of "getting away from it all" by constructive action. It means doing something positive and useful about a problem instead of brooding.

Proceed One Step at a Time

Just sensibly putting one foot ahead of the other and working your way toward a solution can relieve tension, and get you away from the "trapped" feeling that is so deadly. If you are taking steps--however slowly--toward a solution to your problems, then indeed you are not trapped, and can take pride in your ability to handle the situation. In short, learn (and this can be a very gradual process, especially at first) to use tensions and anger by diverting them to worthwhile, reachable goals. It is amazing how much control you have over whether your world runs smoothly; the most important factor is you.

"Kinds" of Mental Illness

The names of different mental or emotional illnesses are simply the "labels" we give them and should not cause fear, in themselves. These days most people do recover, or at least they can be helped.

A Neurosis may be relatively mild, though it may also be emotionally painful, wearing, and to some degree disabling. A neurotic person may be very anxious all the time, for example, or fear heights or closed-in places or crowds. It may be that he can do things only in a certain way, in other words, that he is not flexible. He may suffer from extreme fatigue without an obvious physical cause.

A Personality Disorder is generally a life-long pattern often evident from adolescence or earlier. It may show itself by a lack of good judgment. The person's relationships with others may be poor. There may be little anxiety and no personal sense of distress. In an effort to solve his problems, he may keep repeating the conduct that didn't work in the first place. Others may note that this person doesn't "fit in" or is difficult to work or be with. At times his behavior may be antisocial and injurious to others. He often doesn't seek help until others suggest the need to him.

Psychosis is the name for a mental illness more serious than either neurosis or personality disorder. Often the person cannot function well "in the real world," or at least in some aspects of it. He may not be able to hold a job or assume family responsibilities--at least at first. His behavior may be strange and drive some people away. But even here, in this serious category, there is help today, from drugs, psychotherapy, and modern forms of treatment. Often now with emergency help on tap through community mental health centers or other psychiatric facilities, the psychotic person can live in his home community, get a job or stay on the job he had, and be of help to his family. The old days when the mentally ill person could look forward only to being in a hospital the rest of his life are fairly well over. Hospitalization usually is brief, with return to job and family and outpatient care in the community.

The psychoses include autism in children (severe withdrawal), schizophrenia (a severe break with reality), the manic depressive and involutional depressive illnesses most likely to hit in middle age, senile problems without apparent physical cause (childish behavior, temper tantrums, poor memory and concentration), and the brain damage that may come with hardening of the arteries of the brain.

So far, schizophrenia and autism have proved hard to conquer. Through a variety of drugs, and other medical techniques, as well as psychotherapy, the others are more yielding to treatment. In at least some cases, improvement has been dramatic.

Mental and Emotional Illnesses Can be Treated

People can be helped through drug therapy--the use of tranquilizers, anti-depressants, and other psychotropic drugs. Doctors have also found that shock treatment is helpful for carefully specified conditions. An effort may be made to change the environment of the troubled person, for the time being. And there is group or individual psychotherapy, in which the patient talks with a trained counselor who helps him develop more positive feelings and actions. Other means of help include family therapy, recreational therapy, occupational therapy, art therapy, and psychodrama.

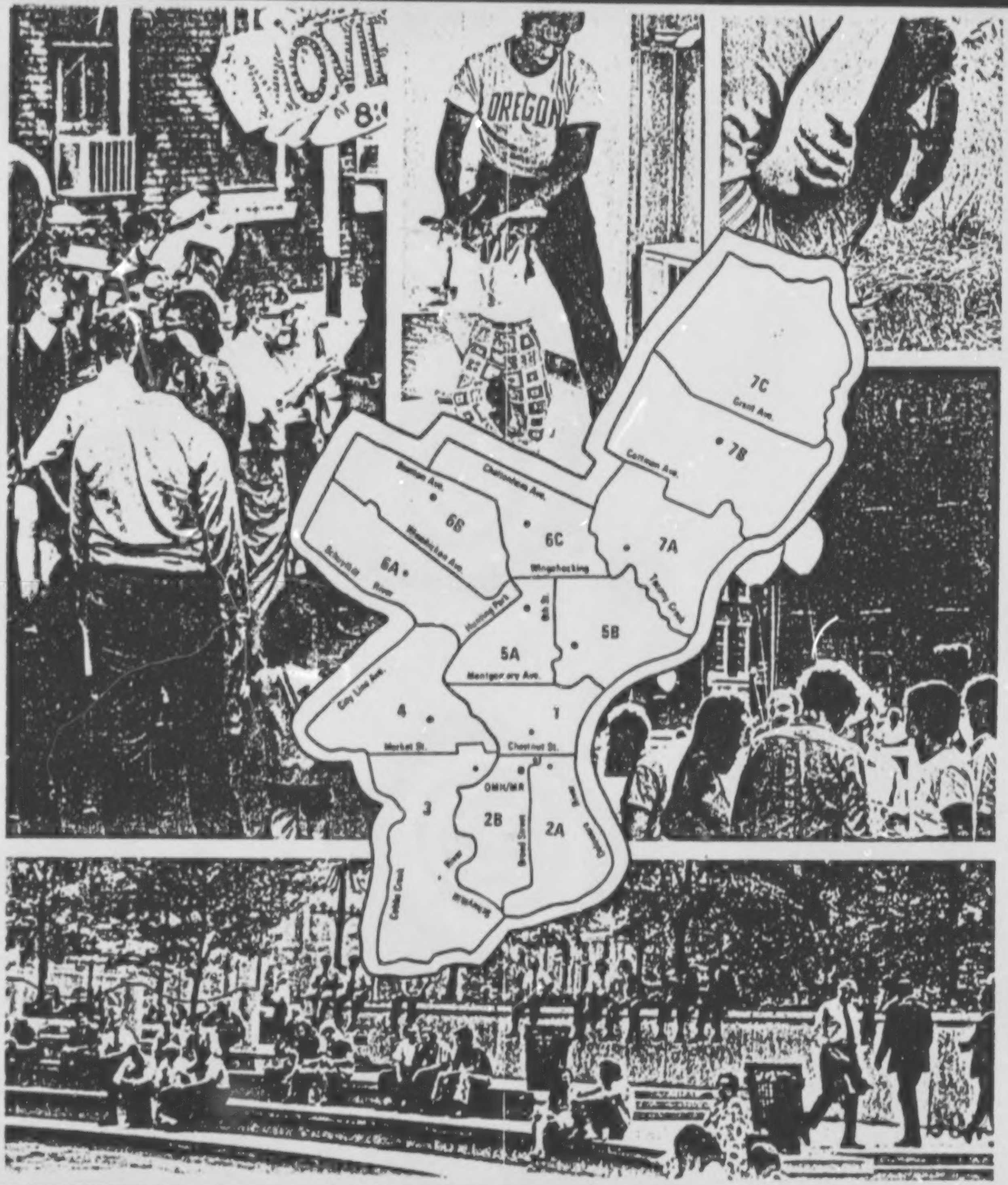
These people can help: whether they are psychiatrists, psychiatric social workers, psychologists, psychiatric nurses, mental health counselors and aides, special therapists, or teachers who are specially trained.

The National Institute of Mental Health has available printed materials on specific problems. Single copies may be obtained without charge by addressing your request to Public Inquiries, National Institute of Mental Health, 5600 Fishers Lane, Rockville, MD, 20852.

Agencies Participating in the Philadelphia Mental Health and Mental Retardation Program

COMMUNITY MENTAL HEALTH/MENTAL RETARDATION CENTERS AND BASE SERVICE UNITS

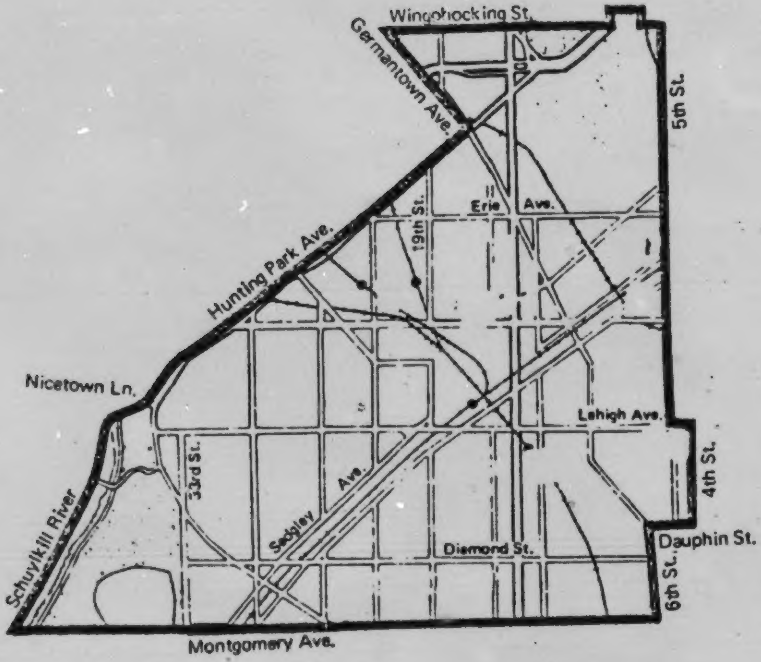
Catchment Area		TELEPHONE
1	Hahnemann Community Mental Health Center Hotel Philadelphia, 11th Floor 314 North Broad Street Philadelphia, Pennsylvania 19102	LO-8-0860
2A	Hall Mercer Community Mental Health and Mental Retardation Center of Pennsylvania Hospital 8th & Locust Streets Philadelphia, Pennsylvania 19107	829-3461
2B	Jefferson Community Mental Health and Mental Retardation Center 1127 Walnut Street Philadelphia, Pennsylvania 19107	829-7676
3	West Philadelphia Community Mental Health Consortium, Inc P.O. Box 8076 (34th & Civic Center Boulevard) Philadelphia, Pennsylvania 19101	EV-7-5000
4	Community Mental Health Center of the Philadelphia Psychiatric Center 4900 Wyalusing Avenue Philadelphia, Pennsylvania 19131	TR-8-7100
5A	North Central Philadelphia Community Mental Health/Mental Retardation Center Beury Building, 5th Floor 3701 North Broad Street Philadelphia, Pennsylvania 19140	226-5000
5B	Episcopal Hospital Base Service Unit 2561 North Front Street Philadelphia, Pennsylvania 19125	GA-6-2583
6A	Inter Community Action, Inc. Base Service Unit 6012 Ridge Avenue Philadelphia, Pennsylvania 19128	IV-7-1700
6B	Northwest Center for Community Mental Health/Mental Retardation Programs 27 East Mount Airy Avenue Philadelphia, Pennsylvania 19119	CH-7-8444
6C	Albert Einstein Community Mental Health and Mental Retardation Center York Road and Somerville Avenue Philadelphia, Pennsylvania 19141	GL-7-7800
7A	Northeast Community Mental Health Center Roosevelt Boulevard and Adams Avenue Philadelphia, Pennsylvania 19124	PI-3-1600
7B	7B Base Service Unit 8040 Roosevelt Boulevard Philadelphia, Pennsylvania 19152	DE-8-9300



CATCHMENT AREA #5A

POPULATION: 208,000

North Central
Community Mental Health and
Mental Retardation Center


Wingohocking St.
Germantown Ave.
5th St.
19th St.
Erie Ave.
Hunting Park Ave.
Nicetown Ln.
Lehigh Ave.
4th St.
33rd St.
Sedgley Ave.
Schuylkill River
Diamond St.
Dauphin St.
6th St.
Montgomery Ave.

North Central Philadelphia CMH/MR Center

Catchment Area #5A

I. Children and Family Unit
Director: Robert Clark, M.D.
3701 N. Broad St.
Phila., Pa. 19140
(215) 226-5000, Ext. 340

Ages Served: Children from ages 1 to 16 and their families and mentally retarded persons of all ages.

Service Locations: Children's services, including intake procedures are centralized at 3701 N. Broad St. Take elevator to 2nd floor and turn right.

Telephone Number: 226-5000 Ext. 340 for all calls, including intake.

Hours: Monday thru Friday, 9-5. Emergency services at the Crisis Center, 24 hours a day, 7 days a week.

Fee Scale: Fees for services are based on a sliding scale, depending upon the income of the family. Fees range from $0 (for welfare and low income families) up to a maximum of $15 per therapy hour. There is a $25 charge for the initial intake interview.

Intake Process: All requests for service should be initiated by the child's parents and should be directed to the receptionist at the 226-500 Ext. 340 number. An intake worker will then record relevant information from the clients and obtain a summary of the referring problem. An appointment is given to the parents (usually within a week's time) for the parents and child to be seen by a two-member intake diagnostic team. Following this intake interview, necessary diagnostic evaluations are scheduled, and the case is presented for staffing. Assignment of a therapist is made at this time and treatment is initiated.

School Referrals: Referrals being initiated by school personnel follow the same procedures as described above. However, it is requested that the parents of a referred child make contact with the intake worker, even if they are being requested to do so by a school staff person.

When action is being taken on a school-based referral a letter is sent to the school counselor stating that the child is being seen at the Center. This is accompanied by a request for school information and a signed parental release form. Notification of therapist assignment is made to the counselor and periodic feedback as to treatment progress is provided.

Children's Services Provided by the Center:

A. Outpatient Services to children and their families include individual, group, family, behavioral and speech therapy. Psychiatric, psychological, educational, and speech evaluations are provided. Medical, neirological and other services are arranged, when indicated.

The mentally retarded child or adult receives evaluation and the appropriate treatment plan is developed. Arrangements can be made for day care, residential placement, public schooling, private schooling, vocational programs, recreational programs and counseling.

B. Emergency Psychiatric Services are provided through the Crisis Center, located in Temple University Hospital on Ontario Street, between Broad Street and Park Avenue. The Crisis Center offers 24-hour daily psychiatric coverage for individuals needing emergency evaluation and treatment.

C. Psychiatric Hospitalization when needed is arranged by the staff in the Children and Family Unit. Temple Hospital and Hahnemann Hospital facilities are used for this purpose.

D. Special Programs

1. School Consultation--Mental health consultation services are provided to numerous schools within the Catchment Area 5A. Individual and group therapy, counselor and teacher consultation, and staff development are among the services currently being provided.

2. Partial Hospitalization School Program--A special program is being operated in the William Dick School for kindergarten and first grade youngsters. Twenty youngsters evidencing significant learning and/or emotional problems are given intensive remediation within a specialized referral classroom. Remedial education, social work, psychological, psychiatric, and medical services are included in the treatment program.

3. Developmental Disabilities Program--This program is designed to provide educational services to mothers of "high risk" infants and children with marked developmental delays. Specially trained child care workers teach the mothers how to provide necessary sensory, cognitive, and emotional stimulation to maximize the child's developmental potential.

MATERIALS DISTRIBUTED TO COUNSELORS AT STAFF DEVELOPMENT SESSION I

OBJECTIVES

- To be able to recognize the multifaceted needs of exceptional students and their families and the consequent requirements for multidisciplinary approaches to identification, assessment and programming:
- To be able to identify what evaluation information is needed for thorough identification, assessment and program planning for exceptional students:
- To have a working knowledge of the various disciplines likely to be involved on CSET teams:
- To recognize the interdependency that is necessary among disciplines in order to integrate each discipline's contribution toward a wholistic picture of students' needs and functioning:
- To recognize the need for on-going involvement of parents or other social-agents in the identification, assessment and programming of exceptional students:
- To identify strategies for encouraging and maintaining on-going involvement of parents or other social agencies as the mobile mental health unit in programming for exceptional students including the use of community agencies where appropriate:
- To know the operating policies, procedures and processes of School-Based Child Study Evaluation Teams

and how to be a contributing member of such teams: and

- To modify existing roles and functions where necessary to work effectively, in an interdisciplinary manner, as members of individual school-based multidisciplinary Child Study Evaluation Teams.

THE CONCEPT OF MULTIDISCIPLINARINESS

By Roy H. Barsch*

In this article, Dr. Barsch defines and discusses the multidisciplinary concept. The concept focuses on the premise that a collective body of knowledge, secured from the various people in the helping professions and disciplines, enables a group to consider all of the available knowledge in resolving the problems of an individual or group.

Dr. Barsch elaborates on how this method of resolving individual and group problems is emerging as a forerunner and flourishing where school staffs are faced with solving the complex learning problems of students. He further states that multidisciplinariness is not exclusively oriented to the diagnosis of a student's needs but is also relevant to therapy, and unless these two steps go hand in hand, the multidisciplinary concept is robbed of its potential.

Dr. Barsch states that only a few centers across the nation have utilized this process to its maximum potential.

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*Ray Barsch, Ph.D., Canoga Park, California, is an educational consultant for public and private schools. Readers wishing to contact Dr. Barsch directly may write to him at 22120 Burton Street, Canoga Park, California 91304. Copies of the original article may be secured from P.R.I.S.E., 443 S. Gulph Road, King of Prussia, Pennsylvania 19406.

Dr. Barsch states that only a few centers across the nation have utilized this process to its maximum potential. He cites several prerequisites needed for a multidisciplinary team to have any significant value. They are as follows:

- A prevailing attitude of mutual respect among the members of the team
  - Competitive interplay dissipates the effectiveness of the team
- A corporate identity
  - The individual disciplines must fuse as one body
- A shifting pattern of leadership according to the dynamics of each case considered
- A staff development or training seminar so that participants can receive training in the multidisciplinary concept
  - If the members are prepared to think as a multidisciplinary team, the possibility of fulfillment exists

Dr. Barsch cites the responsibility of the teacher to become familiar with the helping professions engaged in the multidisciplinary concept. The teacher should read literature, attend seminars, conferences and institutes of other professions to gain as much insight into human learning as they possibly can. He further advocates formal investigation into other disciplines in graduate work if possible. For example, elementary teachers should acquire a master's degree in special education, special education teachers should acquire a master's degree in elementary education, social workers should take an advanced degree in education, psychologists should take an additional degree in special education, and so on.

If school staffs are able to carry out the multidisciplinary concept they will be able to collectively contribute all bodies of knowledge toward the advancement of children and to also enhance and strengthen their own competencies.

MULTI-DISCIPLINE EXPERIENCE: A FRESH APPROACH TO AID THE MULTI-HANDICAPPED CHILD

By William A. Hawke, M.D.
and Aaron Auerbach[*]

Hawke and Auerbach focus on the fact that no one person can possess the knowledge and expertise to meet all of the needs of a multi-handicapped child. Therefore many disciplines functioning in a multidisciplinary approach is crucial in their diagnoses and programming.

They emphasize the fact, however, that a tremendous amount of communication and cooperation is needed to implement a multidisciplinary approach. Unless this occurs, therapy can be fragmented, duplicated or conflicting programs recommended, and some programs emphasized to the detriment of others. The multidisciplinary approach is described as a mosaic approach to therapy in the rehabilitation process.

Social control of the rehabilitation process is then discussed by the authors as the maintenance of an effective chain of control for the purpose of minimizing the handicap. The authors cite that success of the social control in a rehabilitation center depends on seven factors. They are:

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[*] Copies of this article can be secured from P.R.I.S.E., 433 S. Gulph Road, King of Prussia, Pennsylvania 19406.

- The social relations between staff members and between staff and children
- The adaptability of the child
- The orientation of the staff towards the child's problems
- The concept the experts have of themselves
- The rehabilitation program
- The attitudes of therapist and child towards the prognosis
- The acceptance of the child's sexuality

Hawke and Auerbach relate how tensions among the various staff members in working together and relating to others often impede progress. They further discuss the differences in the programs for latency-age versus adolescents and health-oriented versus illness-oriented staffs.

In view of the many problems that the various staff members meet in helping the multi-handicapped child, the authors recommend multi-trained individuals who understand each other's jobs. The specialist model of education is recommended for abandonment. They state that physicians, nurses, psychologists, physical therapists, teachers and social workers should have a common course of lectures and training so that when they begin to work in rehabilitation, they will have a common basic understanding to facilitate the team process. In this way, the team members will not only enhance their own learning but also have a better understanding and appreciation of the roles of other team members.

THE USE OF MANY DISCIPLINES WITH THE SEVERELY AND PROFOUNDLY HANDICAPPED

By Verna Hart[*]

Dr. Hart states that the multidisciplinary concept is not new and that it has been advocated for many years. She indicates that such a concept is not only desirable but critical in meeting the needs of the severely and profoundly handicapped due to their complexities and their age range. She expresses disenchantment, however, with the manner in which most multidisciplinary teams are operating. Instead of working as a team, individuals are working independently without much interaction between members. Therefore, Dr. Hart elaborates in this article on the different approaches school teams can take as they utilize various disciplines in the helping process.

The first is the multidisciplinary approach. She describes this model as evolving from the medical model where various persons with expertise in diverse areas share their particular knowledge in dealing with a particular patient. She cites that in special education, this method has been used in the initial evaluation of the child. The knowledge from the various disciplines represented on the team is integrated to achieve maximum educational gains for the student. Dr. Hart then describes the pitfalls of this approach in working with the severely and profoundly handicapped. Such variables as the background and education of the individual team members often determines the emphasis given to their information. In addition Dr. Hart states that too often the child is discussed and treated in parts and not as a whole child.

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[*] Dr. Hart has coordinated an evaluation program for severely handicapped children and is currently on the faculty at the University of Pittsburgh. Copies of her article can be secured through her directly or through: National Association of State Directors of Special Education, 1201 16 Street NW, Washington, D.C. 20036 or P.R.I.S.E., 443 Gulph Road, King of Prussia, Pennsylvania 19406.

A second approach discussed by Dr. Hart is the interdisciplinary approach. This design involves the use of the same team members used in the multidisciplinary approach, with an attempt to control the fragmentization of their findings. Each team member evaluates the child, but a group decision is made regarding the recommendations for the child. Group consensus is the focus.

Dr. Hart stresses that actual implementation of the above approaches is often difficult and is left to the person least able to carry it out, the classroom teacher. Another weakness in these approaches is the lack of continuous feedback between the team and the classroom teacher. She cites that this weakness is particularly glaring in the case of severely and profoundly handicapped children when the intensity of their multiple problems is so acute.

The transdisciplinary approach is a third model that evolved in an attempt to deal with some of the problems inherent in the other two approaches. The unique feature in this model is that a primary therapist is designated to work with the children. This reduces the fragmentizing and compartmentalization of the child. It is similar to the preceding methods in that a team makes the initial plan, then the therapist carries it out.

The final aspect of this article is the information that teachers of the severely and profoundly handicapped can gain from team approaches. Dr. Hart cites the following data that would be helpful to the teacher:

- Medical information that is invaluable in working with the child
- Psychological information to know the implications of any educational program planned for the child
- Information from the audiologist that enables the teacher to know whether the child responds to any type of sound and what kind of training is recommended for the use of residual hearing
- Information from the social worker or counselor who works with the family and can give insight into family dynamics
- Information from the occupational and physical

therapist that will allow carryover from the physical therapy into the child's total environment, and will not negate the efforts of the therapists

Dr. Hart indicates in her summary that no one person can be expected to have all the necessary skills and information in working with the severely and profoundly handicapped. Therefore some type of team approach must be utilized to meet the varied needs of the student.

GUIDELINES FOR IDENTIFICATION OF THE
MILDLY HANDICAPPED ADOLESCENT

Characteristics

The definition of what constitutes a mildly handicapped adolescent is, of necessity, quite global. For example, a learning disabled person has been described as exhibiting behavior, such as hyperactivity, distractibility, awkwardness, impulsiveness, etc. (Clements 1966). However, these characteristics have been gleaned from studies of young children, not adolescents. Wiederhold (1975) suggests that the studies of characteristics of learning disabled children are likely to have only limited implications for adolescents. By the time a learning disabled child becomes a teenager he has usually learned to control, or mask earlier behaviors associated with a learning disability and has likely developed new symptoms more closely associated with adolescence.

In a review of the literature dealing specifically with mildly handicapped adolescents, it was found that several general categories can be associated with the mildly handicapped adolescent. They can be organized as follows:

1. Basic academic skills are still lacking or have been incorrectly acquired. Success in the academic curriculum will be limited until sufficient survival skills and techniques are mastered which allow the student to function independently in an academic setting.
2. There is a high probability that by adolescence learning disabled students will experience the indirect effects of a learning handicap as manifested by poor self perception, lowered self concept or reduced motivation.

3. The common characteristics associated with young mildly handicapped such as poor coordination, attention, hyperactivity, distractibility and/or aggressive or withdrawn behaviors are likely to manifest themselves in more subtle or controlled ways in the adolescent.

Criteria for Identification

The criteria for screening should encompass the areas of academic achievement, environmental deprivation, motivation, emotional disturbance, sensory deficits and intelligence.

Achievement Criteria

The initial step in identifying a mildly handicapped adolescent lies in establishing the existence of a serious deficit in academic achievement. The areas of reading, mathematics and language are of particular importance. Student performance on standardized achievement tests should reveal a body of individuals who are serious underachievers in any or all of those areas.

Achievement Criteria can be further documented by referring the individual pupils CAT %ile to the CAT %ile conversion chart and determining an achievement grade equivalency.

Motivational Criteria for Special Education Services and Student Involvement in IEP Development

Students who fail to learn solely due to lack of motivation generally are not considered to be exceptional. As student's become older, the extent to which motivational factors influence their school performance steadily increases. Clearly, a remedial special education program has a small chance of success if the student fails to appreciate its importance and resists involvement. Consequently, adolescent students considered candidates for special education programs must be consulted about their educational placement. School personnel must offer eligible students a detailed explanation about the benefits of a remedial program for the mildly handicapped and measure their willingness to participate. Non-handicapped students may require alternate interventions within their regular program to increase motivation toward learning.

In addition to student interest, parental understanding and acceptance of special education services has a critical impact on student's attitude. Consequently parents of students who meet academic eligibility criteria must be insured of procedural safegards and all due process privileges. When appropriate the students themselves may be included.

Emotional Criteria

Failure to learn may be caused by severe emotional disturbance such as neuroses, psychoses, and sociopathic disorders. Children who clearly suffer from such conditions often demonstrate learning deficits. They too require special education services designed to meet their individual needs.

In many cases maladaptive behaviors, i.e. those which are characteristic of emotional disturbance, are precipitated by a learning disability. The determination of the principal causation of such behavior is based essentially upon the severity of the prevailing behaviors.

Sensory Criteria

Students whose failure to learn is caused by poor vision or hearing impairment (acquity) are not considered mildly handicapped. The following procedures should be employed with each eligible student:

1. A comprehensive individual evaluation of near and far point vision must be conducted. Results should be interpreted according to state quidelines regarding the degree of visual impairment which constitutes a handicapping condition. Children who are visually handicapped[1] will be referred for appropriate services.
2. Individual evaluation of hearing impaired[2] will be referred for appropriate services.

Physical Criteria

Failure to learn which is caused primarily by health problems or physical disorders is not indicative of a mildly handicapped adolescent. Students suffering from health or physical impairments such as heart disease, metobolic disorders, cystic fibrosis, muscular dystrophy, nephritis, etc. should be referred for appropriate treatment and/or special education services for crippled and other health impaired. In some cases children suffer from physical disorders which are secondary to severe learning problems.

Intellectual Criteria

All possible candidates must have an individual intelligence evaluation administered by a certified school psychologist. Student's who would qualify for such special education services must have intellectual functionings within the normal range.

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[1] Present Pennsylvania quidelines consider a person visually handicapped whose vision in the best eye is 20/70 or less with correction.

[2] Any child with hearing outside of the normal limits will warrant further investigation.

The purpose of the psychological evaluation is to determine 1) the level of intellectual functioning of the child, and 2) to determine as much as possible the degree to which emotional factors are interfering with the child or youth's academic achievement and over-all functioning. The diagnostic assessment is designed to fulfill two functions. They are: (1) to specify the nature of the students' learning problems and (2) to serve as the basis for determining the individual students' subsequent educational program (I.E.P.). This assessment, conducted by an educational evaluator will reflect, through the use of formal and informal measures, the students specific strengths and weaknesses in a variety of areas. These areas will include reading, mathematics, oral language, written language, spelling and social-emotional development. The evaluation will also include an assessment of motivation, self-concept, and career or vocational interests and aptitudes.

SOME FACTS ABOUT LEARNING DISABILITIES

Block building tests many areas of development. It tests the child's attention span, his ability to deal with frustration, his visual perceptual development and his motor coordination. A preschool child should be able to plan and build a simple structure requiring 10 minutes of patient work. If he cannot, his parents should see that he gets some attention. The child with a learning disability can be helped if the situation is recognized early, dealt with promptly, and the parents are alert and involved. Experience shows that the longer you wait, the worse it gets. There are either one million or four million or eight million learning disabled pre-adolescents in the United States. They account for either one-third or one-half of all juvenile delinquents, school dropouts and emotionally disturbed.

The LD child tests as bright or brighter than his classmates. A deficit, localized in a specific educational skill such as reading, distinguishes him from the mentally retarded who is slow in all areas, and the emotionally disturbed who has problems both in and out of school.

The LD child has a mixup in the way the brain processes information received from the senses, especially in translating symbols into meanings. A learning disability may result from a neurological deficit too slight to be measured. This theory, called minimal brain damage or minimal brain dysfunction, holds that the neural pathways which process information have developed more slowly than normal, or perhaps were slightly damaged before or during birth by illness or injury.

READING DIFFICULTIES: These, the most common disabilities, are sometimes termed "Dyslexia," but this scientific definition actually describes a physical condition caused by damage to that portion of the brain involved in reading skills. Such damage is seldom apparent in examination. In displaying these problems, the reading-disabled child may be unable to distinguish between similar-appearing letters such as "b" and "d" (visual discrimination) or similar sounds such as short "e" and short "i" (auditory discrimination), or he may read from right to left. He may read "on" for "no," "was" for "saw" or "spot" for "stop."

LANGUAGE AND WRITING PROBLEMS: In these cases, the child cannot reproduce written symbols or repeat sounds.

He says "pasketti" for "spaghetti" or "Let's play seek and hide." He may write the entire alphabet and figures in precise mirror image. He may still use baby talk long after his playmates have given it up.

CONCEPTS AND ABSTRACTIONS: Some youngsters are slow to understand what beings or objects have in common. They may quickly and correctly identify a horse, dog, cat and camel, but not be able to categorize them as animals. Sometimes they are unable to grasp concepts of space and time relationships. They confuse after and before, more and less, over and under.

BEHAVIOR: A significant proportion of LD boys cannot seem to sit still, concentrate, or pursue a task through to its conclusion. They are easily distracted, bubbling with energy and often disrupt the classroom routine. This condition, called hyperkinesis, is another center of controversy in the LD story. Some experts believe the hyperkinetics cannot learn because of their short attention span, whereas others say that these students "act out" because learning is so frustrating. There is great difficulty in distinguishing hyperkinesis from simple exuberance. It is sometimes charged that teachers use the label to rid their classrooms of troublemakers and disrupters.

DIAGNOSING LEARNING DISABILITIES: Children with high risk of learning disability can be identified at birth. Premature infants, children of low birth weight and those with a low "Apgar Score," a composite figure calculated at birth and based on heart rate, respiratory effort, muscle tone, reflexes and color--are in this group. A second early identification period comes at about age three. A child who doesn't talk at three probably won't read at six.

With early intervention, good school programs and plenty of support at home, all but a few of the learning disabled can keep abreast of their classmates, or at least catch up with them by the age of 12 or 13. They may never learn in the conventional manner, but will develop their own style of processing and utilizing information. In some ways, the problems may persist into adulthood; they may never read or spell well. Yet many may be gifted creatively or in work with their hands.

AN INTRODUCTION TO MULTIDISCIPLINARY CHILD STUDY EVALUATION TEAMS

"Multidisciplinary" refers to the combining of several disciplines for a common purpose. The concept implies a process where many different branches of learning or expertise collaborate and integrate different kinds of information which leads to some useful action toward solving a problem.

Children with handicaps possess multi-faceted needs and problems which are often pervasive and complex. Proper identification, assessment and programming for these children invites a multidisciplinary approach which would involve the participation of a variety of helping professions. At a minimum, this would include professionals representing the fields of education, social-emotional development, health, psychology and other areas of expertise which are thought to contribute to the total functioning of the child.

In an effective multidisciplinary approach these professionals would have to possess a working knowledge of one another's discipline and a mutual respect and recognition of the interdependency that exists in the team among the fields of knowledge represented. During the course of the evaluation process, these same professionals must engage in on-going communication in relation to the child being evaluated. Finally, the team of evaluators would have to meet in joint conference to collaborate and integrate their information to reach a group-decision for a plan of action to meet the child's needs.

Today, in the public school education of handicapped children, a multidisciplinary approach is not only professionally desirable, it is now the mandate of public law (P.L. 94-142), Commonwealth of Pennsylvania Special Education Standards, and judicial edict (PARC Consent Decree).

The team approach to identification, assessment and planning for handicapped children is mentioned in the Commonwealth of Pennsylvania's Plan for the Identification, Location and Evaluation (COMPILE) of Handicapped Children, as follows:

> From now on it is anticipated that the educational evaluation of sub-normally functioning Commonwealth children will be a continuing multidisciplinary process of individualized assessment, leading to prescriptive program decisions and ready access to appropriate programs for each child. COMPILE (PARC Consent Decree, 1972).

The Education for All Handicapped Children Act of 1975, P.L. 94-142, repeatedly cites the requirement for multidisciplinary approaches in evaluation procedures with handicapped children:

> Sec. 121a.532 Evaluation Procedures
>
> (d) No single procedure is used as the sole

criterion for determining an appropriate educational program for a child; and

(e) The evaluation is made by a multidisciplinary team or group of persons, including at least one teacher or other specialist with knowledge in the area of suspected disability.

(f) The child is assessed in all areas related to the suspected disability, including, where appropriate, health, vision, hearing, social and emotional status, general intelligence, academic performance, communicative status, and motor abilities.

Sec. 121a.533 Placement Procedures

(a) In interpreting evaluation data and in making placement decisions, each public agency shall:

(1) Draw upon information from a variety of sources, including aptitude and achievement tests, teacher recommendation, physical condition, social or cultural background, and adaptive behavior;

(2) Insure that information obtained from all of these sources is documented and carefully considered;

(3) Insure that the placement decision is made by a group of persons, including persons knowledgeable about the child, the meaning of the evaluation data and the placement options;

Sec. 121a.534 Reevaluation

(b) That an evaluation of the child, based on procedures which meet the requirements under 121a.532, is conducted every three years of more frequently if conditions warrant or if the child's parent or teacher requests an evaluation.

The Commonwealth of Pennsylvania Standards for Special Education, in compliance with P.L. 94-142, require multidisciplinary approaches to the identification, evaluation and program planning for handicapped children.

> Sec. 341.13 Evaluation
>
> (e) Other information. Information from sources other than ability or achievement tests, including information from the parents concerning the physical condition, sociocultural background, and adaptive behavior in home and school of the person, shall be considered in making assignments. No one test or type of test shall be used as the sole criterion for development of the Individualized Education Program.
>
> (f) Outside evaluation. Reports and evaluations submitted by the person or parent shall be given full consideration by the school district in recommending assignments. No one test or type of test shall be used as the sole criterion for development of the Individualized Education Program.
>
> (g) Team. All data collected under this section and the relevant school record of the person shall be reviewed and interpreted by a public school psychologist, the present teacher of the person, and a supervisor of special education or another person knowledgeable about the program and service options which may be appropriate for the person. Philadelphia Bulletin, Vol. 7 (40), 10/1/77.

Multidisciplinary teams would be located in each school and consist of the counselor, school nurse, child's present teacher, educational diagnostician, or therapist (speech/hearing/language/PT/OT), certified school psychologist, and any other school district personnel or outside persons who have evaluated the child. The principal maintains overall responsibility for the team and its decisions. Parents are optional members of the team, being given the opportunity to attend joint conferences, but not required to attend.

A multidisciplinary approach to the identification, assessment and program planning for handicapped children in the least restrictive environment requires tremendous role and procedural modifications from those which presently exist in the School District. It is hoped that the multidisciplinary approach to the handicapped will result in improved services for all pupils and a professionally rewarding experience for all staff members.

MATERIALS DISTRIBUTED AT STAFF DEVELOPMENT SESSION II

COUNSELORS STAFF DEVELOPMENT

THE CSET TEAM

Objectives of the Small Group Breakout

- To acquaint participants with the MULTIDISCIPLINARY CHILD STUDY EVALUATION TEAM (CSET).
- To familiarize participants with the members of the CSET.
- To review the roles and responsibilities of the CSET members:
  - general responsibilities of all CSET team members
  - more specific responsibilities of counselors
- To describe CSET operating procedures with emphasis on procedural safeguards.

THE MULTIDISCIPLINARY TEAM: A COMPREHENSIVE PROGRAM FOR DIAGNOSIS AND TREATMENT OF THE RETARDED

By Richard Koch, M.D. and
James C. Dobson, Ph.D.*

The authors of this topic relate how a pediatrician often operates alone in diagnosing and meeting the needs of the retarded child. He or she is forced to provide the intellectual assessment of a psychologist, the understanding and guidance of a social worker or counselor, the medical support of a nurse and the auditory and linguistic evaluation of a speech and hearing consultant.

Koch and Dobson cite how difficult it is for anyone to have the needed expertise in all of these areas to meet the complex needs of the mentally retarded child. Therefore, they recommend the sharing of various disciplines in a team approach in formulating the diagnoses, prescription and care of the retarded child. All team members should participate in all of these steps as they work in cooperation with the parents of the retarded child.

The roles of each team member is then elaborated upon in the following way:

---

*This article is Chapter 11 of The Mentally Retarded Child and His Family: A Multidisciplinary Handbook by Richard Koch. Copies of this article can be secured from P.R.I.S.E., 443 S. Gulph Road, King of Prussia, Pennsylvania 19406.

The Clinical or Educational Psychologist

The psychologist is responsible for the initial evaluation. He or she is responsible for assessing the mental capacity of the child with appropriate tests. The psychologist should meet with the parents if necessary to explain emotional development and other aspects of the parent-child relationship.

The Social Worker

The social worker works intimately with the child and his family extending a warm, understanding and guiding hand to families experiencing hours of great need.

The Nurse

The nurse facilitates medical assessments that are needed and assists the parents in implementing team recommendations.

Speech and Hearing Clinicians

The assessment of speech and hearing is an important part of the team's evaluation. No estimate of intellectual potential is complete until the results of these evaluations are known.

Other Team Members

Input from other disciplines should be included in team meetings depending on the type of mental retardation being evaluated. They could include the nutritionist, educational consultants, occupational and physical therapists and related medical specialists.

Koch and Dobson emphasize in the summary that accurate diagnoses and the most effective course of action can best be formulated by a group of professionals with the specific skills required to evaluate the whole child and his family.

PROCEDURES

The Child Study Evaluation Team shall include but not be limited to the following:

A. Minimal Core Members

- Principal or Designee, Chairperson
- Counselor
- School Nurse
- Educational Diagnostician and/or Teacher
- Certified School Psycholotist

B. Other Team Members (School District)

- Classroom and/or Specialist Teacher and/or Classroom Aide
- Speech/Language, Hearing and Vision Itinerants
- Special Education Supervisor (District and/or Program)
- Counseling Supervisor
- Medical Supervisor
- Physical/Occupational Therapist
- Special Education Medical Consultant
- Social Worker
- Psychiatrist

C. Other Team Members (Non-School District)

- Parents
- Professional Evaluators requested by parents (in writing).
- Representatives of Community Agencies serving the client as requested by the parents (in writing), such as the Mobile Mental Health Staff.

FUNCTIONS OF INDIVIDUAL MEMBERS OF THE SCHOOL-BASED CHILD STUDY EVALUATION TEAM (CSET)

I. GENERAL

In addition to the specific responsibilities designated in the outline below, each member of the Child Study Evaluation Team (CSET) will be expected to:

- prepare a formal report to be included in the student CSET folder;
- file all test protocols in student CSET folder with the exception of those required for use on a daily basis in the instructional program;
- recommend additional assessment/evaluation, if needed;
- record principle findings on a CSET Cumulative Worksheet as soon as assessment is completed which in most cases would be before the formal report is compelted and filed;
- contribute to completion of Team Meeting Report at the final team meeting;
- contribute to the development of the I.E.P., where appropriate.

II. SPECIFIC

The functions indicated below may occur simultaneously, but:

- may not be all inclusive;
- may not be required by each team member in every case;
- may not be mutually exclusive (that is, overlapping and/or sharing of responsibility may be necessary)

A. Minimal Core Members (The core team is likely to increase with the multiplicity and/or severity of the student's handicap(s)

1. Principal

   a. provides overall leadership for the team;

   b. monitors CSET activities so as to insure compliance with procedural safeguards;

   c. arranges for meetings of appropriate team members;

   d. arranges for evaluations, including notification to parents;

   e. assumes responsibility for decision-making regarding school policies and services;

   f. arranges for delivery of ancillary services through contact with appropriate school district offices (see enclosure on Ancillary Services);

   g. clarifies roles and responsibilities of individual team members, if required.

2. School Counselor

   a. serves as general facilitator of the team, and acts as co-chairperson when requested by principal.

   b. opens and maintains student's CSET file;

   c. obtains and/or arranges for the collection of case/developmental history if not otherwise available;

   d. provides information about student and family that will enable team members to perform needed evaluations, observations, and written reports;

   e. discusses aspects of team's functions with principal when administrative decisions and joint planning are indicated, including the scheduling of meetings and additional evaluations;

f. provides counseling services to the student and his/her parents on a continuous basis throughout the evaluation and placement process, giving them information regarding the process and their rights;

g. assists parents in obtaining community-based services when indicated by the team;

h. prepares Team Meeting Report at final team meeting;

i. interprets the team findings and recommendations to the parents and counsels them regarding the nature of the student's programatic needs including both Special Education and other services.

3. School Nurse

a. reviews the student's health and medical records;

b. screens sensory functions;

c. recommends additional medical or physical evaluations as needed;

d. arranges for additional medical/physical evaluations;

e. collects all health and medical evaluation reports from school district and outside sources;

f. interprets health and medical information to other team members;

g. communicates with parents regarding the student's health and medical needs.

4. Educational Diagnostician (in conjunction with classroom and/or specialist teachers)

a. identifies areas of concern in educational program including aspects of curriculum and learning style;

b. identifies appropriate educational assessment instruments and/or techniques;

c. identifies available personnel to perform educational assessments;

d. assists personnel identified to perform educational assessments by providing appropriate assessment instruments and/or training in assessment techniques, if requested;

e. performs educational assessment as required;

f. integrates all relevant educational assessment data;

g. reports results of educational assessment at team meetings;

h. consults with other team members and assists team in identifying priority areas for program and services;

i. contributes to the development of the I.E.P. indirectly, by assisting teachers and/or therapists in the identification of annual goals and short-term objectives consistent with the team's Cumulative Worksheet and Team Meeting Report;

j. contributes to the development of the I.E.P. directly, by generating annual goals and short-term objectives, as above;

k. assists in the implementation and determination of the appropriateness of the I.E.P. on an on-going basis.

5. Certified School Psychologist

a. consults with other team members, school personnel, agency personnel, and others as indicated to review student's records;

b. meets with parent(s), if requested, or if completeness of the individual psychological evaluation so requires;

c. observes student in school milieu;

d. consults with student's teacher(s);

e. administers psychological testa and other instruments required for a sufficient and complete evaluation;

f. reports the degree of suspected or identified handicap, if any, and interprets results of test data at team meeting;

g. discusses with other team members diagnostic hypotheses and proposed intervention strategies;

h. consults with other team members and assists team in identifying priority areas for programs and services.

B. Other Team Members

- School Assigned

1. Classroom And/Or Specialist Teacher

   a. provides documented objective and subjective information about the student's classroom performance, including intervention attempts;

   b. notes areas of concern in educational program including aspects of curriculum and learning style;

   c. cooperates with educational diagnostician and other specialist teachers involved to determine:

      1) appropriate assessment instruments

      2) appropriate assessment techniques

      3) availability of personnel for assessment;

d. performs educational assessment as required;

e. reports results of educational assessment at team meetings;

f. consults with other team members and assists team in identifying priority areas for program and services.

2. Speech/Language/Hearing Therapist

a. reviews all student records, including health and medical records, psychological records, speech records, audiological records, and student/family history records;

b. contacts or meets with parents in order to obtain significant history pertaining to speech, language, and hearing development;

c. observes student in classroom and in other school situations and consults with classroom teachers;

d. administers formal and informal speech, language, and hearing assessments (this may include a brief period of diagnostic therapy);

e. interprets data to other team members at team meetings;

f. consults with other team members and assists team in identifying priority areas for program and services.

- District Assigned

1. Special Education Supervisor

a. facilitates district office support to the team;

b. acts as resource person with respect to the various Special Education programs and services available in the district;

c. assures that the CSET's procedures and recommendations are in accordance with Federal Regulations, State Standards, and School District policies for Special Education;

d. acts as liason between/among school, district office, central office, and community agency personnel;

e. visits on a regular schedule, each school under his/her supervision in which there is a CSET;

f. assists principal in accessing Special Education services currently not available in the school;

g. assumes responsibility for resolving discrepancies, if any, between/among team members' recommendations for Special Education placement, program, and/or services.

2. Counseling Supervisor

   a. facilitates district and/or central office support to the team;

   b. acts as a resource person to the team;

   c. provides supervision and/or assistance to the team counselor;

   d. assists principal in accessing Counseling services currently not available in the school.

3. Medical Supervisor

   a. facilitates district and/or central office support to the team;

   b. acts as a resource person to the team;

   c. provides supervision and/or assistance to the team health personnel;

d. assists principal in accessing Medical services currently not available in the school.

- Central Office Assigned

1. Special Education Medical Consultant (in collaboration with school nurse and/or PT/OT)
    - a. reviews the student's medical history and school/home performance reports;
    - b. evaluates educational implications of the student's medical problems;
    - c. performs medical/physcial evaluations, when required;
    - d. reports results of medical evaluations at team meetings, when required;
    - e. consults with other team members and assists team in identifying priority areas for program and services, when required.
2. Social Worker
    - a. acts as liason between/among the school, the home, and community agencies, including home visits and interviews, when indicated;
    - b. explains educational regulations and policies to parents;
    - c. collects and integrates all relevant familial data;
    - d. reports familial data at team meetings;
    - e. consults with other team members and assists team in identifying priority areas for program and services.
3. Psychiatric Consultant
    - a. reviews all existing relevant data;

- b. consults with school personnel concerning the student's school behavior;
- c. observes student in school milieu;
- d. performs psychiatric evaluation--(usually in the form of a developmental history-taking session with the parent and a semi-structured diagnostic interview with the student);
- e. interprets and reports results of psychiatric evaluation at team meetings, when indicated;
- f. acts as liaison between/among the family, school, and community agencies in considering placement and service options for therapeutic purposes, in consultation with, and as recommended by the team;
- g. consults with other team members and assists team in identifying priorities for program and services.

4. Vision Itinerant Teacher

   - a. reviews student records, including health and medical records, psychological records, ophthalmological records, and student/family history records;
   - b. identifies up-dated and/or additional evaluations required;
   - c. performs required vision assessments/ evaluations as required;
   - d. interprets and reports results of vision evaluations at team meetings;
   - e. consults with other team members and assists team in identifying priorities for programs and services.

5. Physical Therapist/Occupational Therapist

   a. reviews all existing relevant data, including health and medical records, psychological records, PT/OT records and student/family history records;

   b. identifies updated and/or additional assessments/evaluations as indicated;

   c. performs required assessment/evaluations with projected evaluation dates;

   d. interprets and reports results of PT/OT evaluations at team meeting;

   e. consults with other team members and assists team in identifying priority areas for programs and services.

THE SPECIFIC DUTIES OF THE SCHOOL COUNSELOR ON THE MULTIDISCIPLINARY TEAM HIGHLIGHTED

- Serves as Co-Chairperson for the team and general facilitator of the school based child study evaluation team's processes.
- Provides information about pupil and family that will enable each team member to perform needed evaluations, observations and written reports.
- Discusses data with principal when administrative decisions and joint planning are indicated.
- Arranges for meetings of the school-based team.
- Informs child and parents of their rights and works with them, on an on-going basis in relation to the evaluation and placement processes.
- Prepares summary of his/her interviews with the pupil and parents.
- Plans for outside evaluations which have been recommended by the team. Such evaluations might include:
    - Social work milieu report
    - Psychiatric evaluation
    - Neurological evaluation
    - Additional medical evaluations
    - Sensory evaluations
    - Developmental evaluations
    - Agency reports or evaluations

STUDENT OBSERVATION FORM

STUDENT OBSERVATION FORM

Student's name ____________ School ____________ District # ____

Grade ____________ Room # ____________

Observer's name ____________ Observation Date ____________

Suggested starting times for observation ____________ or ____________ or ____________

OBSERVATION	NOTES
I. Setting--circumstances in which student is being observed	
Indicate: 1. Subject of lesson: a) reading b) math c) other ____________	
2. Type of lesson: a) teacher-directed b) peer-directed c) self-directed d) other ____________	
3. Type of Work Group: a) individualized b) cooperative c) competitive d) other ____________	
4. Size of Work Group: a) alone b) with one person c) with small group d) total class e) other ____________	
5. Instructional Approach: a) visual b) auditory c) tactile-kinesthetic d) other ____________	

Describe:

6. Student's location in class:

7. Activities in which student is involved:

8. Instructional materials used:

OBSERVATION	NOTES

II. Learning characteristics-- demonstrated during observation

Indicate:

1. Attention Span:
    - a) regularly attentive
    - b) short periods of attention/ concentration
    - c) irregular (distracted) attention
    - d) generally inattentive
    - e) other ____________

2. Attitude:
    - a) relaxed — tense
    - b) impulsive — reflective
    - c) cooperative — resistent
    - d) passive — aggressive
    - e) independent — dependent
    - f) other: ________ — ________

Describe:

3. Student's responses to:
    - a) directions
    - b) materials ____________
    - c) instructional methods ____________
    - d) teacher/aide ____________

4. Interaction with peers during observation

5. Non-directed behaviors

III. Duration of observation:
starting time ____________ ending time ____________ total ____________

IV. Observation information shared with classroom teacher Yes ____ No ____
Teacher Comments:

Classroom teacher's impression of student behaviors observed:
typical atypical

COUNSELORS CSET HANDBOOK

PREFACE

This handbook has been compiled by the counseling supervisor to serve as a resource for school counselors serving on school Child Study Evaluation Teams. It also includes the role of community agencies such as the mobile mental health unit in the functioning of these teams.

The second part of the handbook focuses on the procedural safeguards counselors must follow in carrying out their roles as members of CSET teams.

It should serve as a guide until formal guidelines are written and distributed by the Philadelphia School District.

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INTRODUCTION

Public Law 94-142 has had a great impact on the role of the school counselor. Implementing this law has become the number one priority of the Philadelphia School System. It is imperative, therefore, for counselors to have a general knowledge of the law and its specific guidelines that affect their daily working relationships with students, staff, parents and community agencies.

The primary purpose of this handbook is to acquaint each counselor with the new procedures that they are to utilize in implementing P.L. 94-142. The School District will be editing a formal special education manual in the near future. This handbook will serve as a guide until such a document is available from the Philadelphia School District.

The Changing Role of Counselors

The emphasis on counseling is changing constantly and dramatically since the passage of Public Law 94-142. Counselors are trying to find their place in the implementation of this new law.

Instead of working mainly with children who are considered to be in the mainstream of education, counselors are now expected to concentrate their energies on children who are identified as handicapped or exceptional. The result of this is that students who do not present special educational problems may not receive as much attention from the counselor with individual problems in learning and other aspects of growth.

Counseling has always been a supportive service for children and their parents within the educational and social context; however, recent legislation and court orders require counselors to serve, both in direct and indirect ways, the immediate needs and interests of special education children.

Background

Public Law 94-142 guarantees a free appropriate public education for all children identified in need of special education. It was passed by near unanimous acclaim by Congress and signed into law on November 29, 1975. This landmark law entitled the Education of All Handicapped Children Act of 1975 not only declares the appropriate procedures to achieve such an educational program for the handicapped, but also authorizes the expenditure of federal money to provide the necessary services for the implementation of the act.

Pennsylvania state law also requires that each handicapped child has the right to a free public education which meets his or her special instructional needs. During the past two years, the Pennsylvania Department of Education has issued regulations designed to insure an appropriate educational program for the handicapped. All remifications of these regulations must be implemented in the School District of Philadelphia.

If the implementation of P.L. 94-142 is an evolutionary process that will proceed over a period of years, it is essential that school counselors find their place within the framework of service and delivery systems so that the impact of P.L. 94-142 on counselors can be shaped in an orderly and meaningful way. Counselors will become intimately involved with P.L. 94-142 either through choice or because it will be thrust upon them.

Overview of P.L. 94-142

Essentially the law guarantees a free, appropriate public education for all handicapped children between the ages of 3 and 21. It is permanent legislation with no expiration date.

The legislative intent of the law was to provide adequately for the large number of handicapped whose needs were not fully met or either denied.

Among the concepts addressed are:

- institutional and due process rights
- individualized educational programs including their development and evaluation
- parental involvement
- appropriate assessment techniques
- confidentiality of data
- least restrictive environment

Aspects of P.L. 94-142 Relating Immediately to Counselors

Alo aspects of the law have a direct or indirect relationship to counselor function. The following areas, however, are immediately applicable:

Free Appropriate Public Education

Special education and related services that are provided at public expense and under public supervision must meet state and federal guidelines. This includes preschool, elementary, and secondary education in accordance with an I.E.P. This service covers all children from ages 3 to 21 years of age beginning September 1, 1978.

Handicapped Children*

Handicapped children are those who are:

- mentally retarded
- hard of hearing
- deaf
- speech impaired
- visually handicapped
- seriously emotionally disturbed
- orthopedically and other health impaired
- deaf-blind
- learning disabled
- multi-handicapped

Related Services

Related services include:

- transportation
- speech pathology and audiology
- psychological services
- physical and occupational therapy
- recreation
- Counseling Services
- medical services for diagnosis and evaluation

---

* See Appendix A for a more detailed description.

- social work services
- parent counseling and training*

Counseling service must be provided by guidance counselors, social workers, psychologists or other qualified personnel. Qualified means certified, licensed or registered.

Special Education

Special education is specially designed instruction to meet the unique needs of a handicapped child, including classroom instruction, instruction in physical education, home instruction, and instruction in hospitals and institutions.

It also includes vocational education. (This implies career awareness which will probably be delegated to the counselor.)

Individualized Educational Programs (I.E.P.'s)

I.E.P.'s are written documents for each handicapped child that must include:

- Statement of the child's present levels of educational performance.
- A statement of annual goals including short-term objectives.
- A statement of the specific special education and related services to be provided and the extent to which there will be participation in regular educational programs.
- The dates for initiation of services and the duration of the services.
- Appropriate objective criteria, evaluation procedures and schedules for determining whether the short-term instructional objectives have been met.

Meetings to develop the I.E.P. shall have as participants:

---

* Parent counseling seems to indicate an informational rather than a therapeutic emphasis for the counselor.

- Representatives of the facility other than the child's teacher, who is qualified to provide or supervise special education.
- The child's teacher.
- The child's parent or parents or guardian.
- The child, where appropriate.
- Other individuals as invited by the parent or agency.

All reasonable steps must be taken to ensure that parents are present and, if this is not possible, a detailed record of contact attempts must be maintained. (The guidance counselor will play a major role if mainstreaming is a part of the plan.)

Personnel Development*

Personnel development must be a part of each annual program plan and include inservice training of general and special education instruction, related services and support personnel, as well as scheduled procedures for acquiring and disseminating information to teachers and administrators who deal with handicapped children.

Due Process Procedures

Due process procedures cover the procedural safeguards that govern both evaluation and programming. In terms of evaluation, the parent must fully be informed in his or her native language. The parent must understand and agree in writing to the carrying out of an activity; and the parent must understand that the granting of consent is voluntary.

* In the early stages of P.L. 94-142 implementation, counselors will be the recipients of inservice training along with other groups. However, in the future, counselors will be called upon to provide inservice training to other staff members.

As a part of their job functions, counselors have always been asked to interpret pupil behavior and progress to teachers, parents and administrators as well as facilitate educational environment changes for the benefit of students. This function would logically extend to handicapped children.

Further, the parent can examine all records and obtain an independent evaluation. Prior written notice must also be given to the parent within a reasonable amount of time for purposes of identification, evaluation or educational placement.

A parent or public agency may initiate a hearing on any of the above matters which must be conducted by an impartial hearing officer. Appeals to hearing decisions can be made sequentially to the state educational agency and to the courts.

NOTE: A significant part of due process procedures centers around the maintenance of adequate records. This attention to records is important because without documentation there can be no evidence of procedural integrity.

Much of the documentation will have the child's cumulative record as its repository. The cumulative record is interpreted frequently to parents by counselors, and parental perceptions will emanate from these interpretations.

Due to the fact that counselors often have more ready access to teachers, test scores and program reports, they may be delegated the responsibility for seeing that the due process procedures are followed. Hearing procedures may also require counselors as witnesses.

This entire area makes it crucial for counselors to be familiar with the law and procedural safeguards.

Least Restrictive Environment

To the maximum extent appropriate, handicapped children are to be educated with the non-handicapped. The placement is decided annually as based on the I.E.P.

Non-academic settings and extracurricular activities must also provide for a least restrictive environment. This means that meals, recess periods and the like must provide for mingling with non-handicapped children. (NOTE: The counselor may be involved in making instructional and curriculum recommendations. At the secondary level, this may include scheduling expertise to insure the correct match with the student, teacher and curriculum.

When a handicapped child is successfully mainstreamed, counseling will probably be an integral part of the I.E.P.

in order to maintain the child in the regular program.)

Confidentiality of Information

Confidentiality of information follows the regulations of the Family Educational Rights and Privacy Act of 1974. In general, parental consent must be obtained before personally identifiable information can be released to anyone. Rights of parents regarding education are transferable to students usually at age 18 depending on the type of severity or disability.

Parents shall be permitted to inspect and review any educational records that are collected, maintained and used. They may have a copy and may request the deletion of inaccurate or misleading information to be decided by a hearing if the school personnel disagree. (NOTE: This entire area is the counselors domain.)

Concept of the Multidisciplinary Team Approach

Rationale

"Multidisciplinary" refers to the combining of several disciplines for a common purpose. The concept implies a process where many different branches of learning or expertise collaborate and integrate different kinds of information which leads to some useful action toward solving a problem.

Children with handicaps possess multi-faceted needs and problems which are often pervasive and complex. Proper identification, assessment and programming for these children invites a multidisciplinary approach which would involve the participation of a variety of helping professions. At a minimum, this would include professionals representing the fields of education, social-emotional development, health, psychology and other areas of expertise which are thought to contribute to the total functioning of the child.

In an effective multidisciplinary approach these professionals would have to possess a working knowledge of one another's discipline and a mutual respect and recognition of the interdependency that exists in the team among the fields of knowledge represented. During the course of the evaluation process, these same professionals must engage in on-going communication in relation to the child being evaluated. Finally, the team of evaluators would have to meet in joint conference to collaborate and integrate their information to reach a group-decision for a plan of action to meet the child's needs.

Legal Mandates

Today, in the public school education of handicapped children, a multidisciplinary approach is not only professionally desirable, it is now the mandate of public law (P.L. 94-142), Commonwealth of Pennsylvania Special Education Standards, and judicial edict (PARC Consent Decree).

The team approach to identification, assessment and planning for handicapped children is mentioned in the Commonwealth of Pennsylvania's Plan for the Identification, Location and Evaluation (COMPILE) of Handicapped Children, as follows:

> From now on it is anticipated that the educational evaluation of sub-normally functioning Commonwealth children will be a continuing multidisciplinary process of individualized assessment, leading to prescriptive program decisions and ready access to appropriate programs for each child. COMPILE (PARC Consent Decree, 1972).

The Education for All Handicapped Children Act of 1975, P.L. 94-142, repeatedly cites the requirement for multidisciplinary appropaches in evaluation procedures with handicapped children:

> Sec. 121a.532 Evaluation Procedures
>
> (d) No single procedure is used as the sole criterion for determining an appropriate educational program for a child; and
>
> (e) The evaluation is made by a multidisciplinary team or group of persons, including at least one teacher or other specialist with knowledge in the area of suspected disability.
>
> (f) The child is assessed in all areas related to the suspected disability, including, where appropriate, health, vision, hearing, social and emotional status, general intelligence, academic performance, communicative status, and motor abilities.
>
> Sex. 121a.533 Placement Procedures
>
> (a) In interpreting evaluation data and in making placement decisions, each public agency shall:
>
> (1) Draw upon information from a variety of sources, including aptitude and achievement tests, teacher recommendation, physican condition, social or cultural background, and adaptive behavior;
>
> (2) Insure that information obtained from all of these sources is documented and carefully considered;

> (3) Insure that the placement decision is made by a group of persons, including persons knowledgeable about the child, the meaning of the evaluation data and the placement options;
>
> Sec. 121a.534 Reevaluation
>
> (b) That an evaluation of the child, based on procedures which meet the requirements under 121a.532, is conducted every three years or more frequently if conditions warrant or if the child's parent or teacher requests an evaluation.

The Commonwealth of Pennsylvania Standards for Special Education, in compliance with P.L. 94-142, require multidisciplinary approaches to the identification, evaluation and program planning for handicapped children.

> Sec. 341.13. Evaluation
>
> (e) Other information. Information from sources other than ability or achievement tests, including information from the parents concerning the physical condition, sociocultural background, and adaptive behavior in home and school of the person, shall be considered in making assignments. No one test or type of test shall be used as the sole criterion for development of the Individualized Education Program.
>
> (f) Outside evaluation. Reports and evaluations submitted by the person or parent shall be given full consideration by the school district in recommending assignments. No one test or type of test shall be used as the sole criterion for development of the Individualized Education Program.
>
> (g) Team. All data collected under this section and the relevant school record of the person shall be reviewed and interpreted by a public school psychologist, the present teacher of the person, and a supervisor of special education or another person knowledgeable about the program and service options which may be appropriate for the person.
> ...Pennsylvania Bulletin, Vol. 7, (40), 10/1/77.

For most handicapped students, their free and appropriate education will take place in schools which house mostly regular class students. The Child Study Evaluation Team has been established to provide a multidisciplinary approach to evaluation and placement. This core team will help school staff meet their responsibilities and effectively plan programs for the handicapped. The composition of the Child Study Evaluation Team (CSET) follows.

The Child Study Evaluation Team

Composition

The Child Study Evaluation Team shall include but not be limited to the following:

a. Minimal Core Members

    1) Principal or Designee, Chairperson
    2) Counselor
    3) School Nurse
    4) Educational Evaluator
    5) Certified School Psychologist

b. Other Possible Team Members (School District)

    1) Classroom and/or Specialist Teacher and/or Classroom Aide
    2) Speech/Language, Hearing and Vision Itinerants
    3) Special Education Supervisor (District and/or Program)
    4) Counseling Supervisor
    5) Medical Supervisor
    6) Physical/Occupational Therapist
    7) Special Education Medical Consultant
    8) Social Worker
    9) Psychiatrist
    10) Attendance Officer
    11) Home & School Coordinator

c. Other Team Members (Non-School District)

    1) Parents
    2) Professional evaluators requested in writing by the parents
    3) Representatives of community agencies serving the child as requested in writing by the parents such as staff from the mobile mental health unit

All members of the Child Study Evaluation Team are under the direct supervision of the building principal while functioning on the school based team.

FUNCTIONS OF INDIVIDUAL MEMBERS OF THE SCHOOL-BASED CHILD STUDY EVALUATION TEAM (CSET)

General

In addition to the specific responsibilities designated in the outline below, each member of the Child Study Evaluation Team (CSET) will be expected to:

- prepare a formal report to be included in the student CSET folder;
- file all educational test protocols in student CSET folder with the exception of those required for use on a daily basis in the instructional program;
- recommend additional assessment/evaluation, if needed;
- record principle findings on the CSET Cumulative Worksheet as soon as assessment is completed, which in most cases would be before the formal report is completed and filed;
- contribute to completion of Team Meeting Report at the final team meeting;
- contribute to the development of the I.E.P., where appropriate.

Specific

The functions indicated below may occur simultaneously, but:

- may not be all inclusive;
- may not be required by each team member in every case;
- may not be mutually exclusive (that is, overlapping and/or sharing of responsibility may be necessary).

A. Core Members (The core team is likely to increase with the multiplicity and/or severity of the student's handicap(s).

1. Principal

   a. provides overall leadership for the team;

   b. monitors CSET activities so as to insure compliance with procedural safeguards;

   c. arranges for meetings of appropriate team members;

   d. arranges for evaluations, including notification to parents;

   e. assumes responsibility for decision-making regarding school policies and services;

   f. arranges for delivery of services through contact with appropriate school district offices;

   g. clarifies roles and responsibilities of individual team members, if required.

2. School Counselor

   a. serves as general facilitator of the team, and acts as co-chairperson when requested by principal;

   b. opens and maintains student's CSET file;

   c. obtains and/or arranges for the collection of case/developmental history, if not otherwise available;

   d. provides information about student and family that will enable team members to perform needed evaluations, observations, and written reports;

   e. discusses aspects of team's functions with principal when administrative decisions and joint planning are indicated, including the scheduling of meetings and additional evaluations;

   f. provides counseling services to the student and his/her parents on a continuous basis throughout the evaluation and placement process, giving them information regarding the process and their rights;

g. assists parents in obtaining community-based services when indicated by the team;

h. prepares Team Meeting Report at final team meeting;

i. interprets the team findings and recommendations to the parents and counsels them regarding the nature of the student's programatic needs including both Special Education and other services.

3. School Nurse

a. reviews the student's health and medical records;

b. screens sensory functions;

c. recommends additional medical or physical evaluations as needed;

d. arranges for additional medical/physical evaluations;

e. collects all health and medical evaluation reports from school district and outside sources;

f. interprets health and medical information to other team members;

g. communicates with parents regarding the student's health and medical needs.

4. Educational Evaluator (in conjunction with classroom and/or specialist teachers)

a. identifies areas of concern in educational program including aspects of curriculum and learning style;

b. identifies appropriate educational assessment instruments and/or techniques;

c. identifies available personnel to perform educational assessments;

d. assists personnel identified to perform educational assessments by providing appropriate assessment instruments and/or training in assessment techniques, if requested;

e. performs educational assessment as required;

f. integrates all relevant educational assessment data;

g. reports results of educational assessment at team meetings;

h. consults with other team members and assists team in identifying priority areas for program and services;

i. contributes to the development of the I.E.P. indirectly, by assisting teachers and/or therapists in the identification of annual goals and short-term objectives consistent with the team's Cumulative Worksheet and Team Meeting Report;

j. will observe the child's classroom performance upon direction from the principal;

k. contributes to the development of the I.E.P. directly, by generating annual goals and short-term objectives, as above;

l. assists in the implementation and determination of the appropriateness of the I.E.P. on an on-going basis.

5. Certified School Psychologist

a. consults with other team members, school personnel, agency personnel, and others as indicated to review student's records;

b. meets with parent(s), if requested, or if completeness of the individual psychological evaluation so requires;

c. observes student in school mulieu;

d. consults with student's teacher(s);

e. administers psychological tests and other instruments required for a sufficient and complete evaluation;

f. reports the degree of suspected or identified problem, if any, and interprets results of test data at team meeting;

g. discusses with other team members diagnostic hypotheses and proposed intervention strategies;

h. consults with other team members and assists team in identifying priority areas for programs and services.

B. Other Team Members

- School Assigned

1. Classroom And/Or Specialist Teacher

a. provides documented objective and subjective information about the student's classroom performance, including intervention attempts;

b. notes areas of concern in educational program including aspects of curriculum and learning style;

c. cooperates with educational diagnostician and other specialist teachers involved to determine:

1) appropriate assessment instruments;

2) appropriate assessment techniques;

3) availability of personnel for assessment.

d. performs educational assessment as required;

e. reports results of educational assessment at team meetings;

f. consults with other team members and assists team in identifying priority areas for program and services.

2. Speech/Language/Hearing Therapist

a. reviews all student records including health and medical records, psychological records, speech records, audiological records, and student/family history records;

b. contacts or meets with parents in order to obtain significant history pertaining to speech, language, and hearing development;

c. observes student in classroom and in other school situations and consults with classroom teachers;

d. administers formal and informal speech, language, and hearing assessments (this may include a brief period of diagnostic therapy);

e. interprets data to other team members at team meetings;

f. consults with other team members and assists team in identifying priority areas for program and services.

- District or Central Office Assigned

1. Special Education Supervisor

a. facilitates district office support to the team;

b. acts as resource person with respect to the various Special Education programs and services available in the district;

   c. assures that the CSET's procedures and recommendations are in accordance with Federal Regulations, State Standards, and School District policies for Special Education;

   d. acts as liaison between/among school, district office, central office, and community agency personnel;

   e. visits on a regular schedule each school under his/her supervision in which there is a CSET;

   f. assists principal in accessing Special Education services currently not available in the school;

   g. assumes responsibility for resolving discrepancies, if any, between/among team members' recommendations for Special Education placement, program, and/or services.

2. Counseling Supervisor

   a. facilitates district and/or central office support to the team;

   b. acts as a resource person to the team;

   c. provides supervision and/or assistance to the team counselor;

   d. assists principal in accessing counseling services currently not available in the school.

3. Medical Supervisor

   a. facilitates district and/or central office support to the team;

   b. acts as a resource person to the team;

   c. provides supervision and/or assistance to the team health personnel;

   d. assists principal in accessing medical services currently not available in the school.

4. Special Education Medical Consultant

   a. reviews the student's medical history and school/home performance reports;

   b. evaluates educational implications of the student's medical problems;

   c. performs medical/physical evaluations, when required;

   d. reports results of medical evaluations at team meetings, when required;

   e. consults with other team members and assists team in identifying priority areas for program and services, when required.

5. Social Worker

   a. acts as liaison between/among the school, the home, and community agencies, including home visits and interviews, when indicated;

   b. explains educational regulations and policies to parents;

   c. collects and integrates all relevant familial data;

   d. reports familial data at team meetings;

   e. consults with other team members and assists team in identifying priority areas for program and services.

6. Psychiatric Consultant

   a. reviews all existing relevant data;

   b. consults with school personnel concerning the student's school behavior;

   c. observes student in school milieu, where appropriate;

   d. performs psychiatric evaluation--(usually in the form of a developmental history--taking sessions with the parent and a semi-structured diagnostic interview with the student);

   e. interprets and reports results of psychiatric evaluation at team meetings, when indicated;

   f. acts as liaison between/among the family, school, and community agencies in considering placement and service options for therapeutic purposes, in consultation with, and as recommended by the team;

   g. consults with other team members and assists team in identifying priorities for program and services.

7. Vision Itinerant Teacher

   a. reviews student records, including health and medical records, psychological records, ophthalmological records, and student/family history records;

   b. identifies updated and/or additional evaluations required;

   c. performs required vision assessments/evaluations as required;

   d. interprets and reports results of vision evaluations at team meetings;

   e. consults with other team members and assists team in identifying priorities for programs and services.

8. Physical Therapist/Occupational Therapist

   a. reviews all existing relevant data, including health and medical records, psychological records, PT/OT records and student/family history records;

   b. identifies updated and/or additional assessments/evaluations as indicated;

   c. performs required assessment/evaluations consistent with projected evaluation dates;

   d. interprets and reports results of PT/OT evaluations at team meeting;

   e. consults with other team members and assists team in identifying priority areas for programs and services.

9. Representatives from Community Agencies

   a. reviews all existing relevant data;

   b. performs required assessment/evaluations for students receiving their service;

   c. observes students in school milieu, where appropriate;

   d. works through the school counselor as a liaison between the agency and the school staff;

   e. interprets and reports results of assessments/evaluations done at the agency;

   f. implements therapeutic needs of students where the agency's services are required;

   g. serves as a child-parent advocate advising them of due process relating to evaluative and placement procedures;

   h. accompanies or represents parent at team meetings at their request;

   i. serves as a team member and consults with other team members and assists team in identifying priorities for programs and services.

Procedural Safeguards

Introduction

The law is not always followed the way it is supposed to and P.L. 94-142 will be no exception. Therefore, if somewhere along the process, parents feel that their rights are being denied, they can follow certain steps.

If at any phase of the planning and programming for their child, parents feel that they are not getting cooperation, they may appeal to the principal and ultimately to the Board of Education.

Once disputes or disagreements are spelled out between the parents and the school, the law sets forth procedures that parents can use to appeal the school's decision regarding the placement and program for their child. Impartial hearings become the forum for resolving concerns and disagreements.

It should be remembered that parents and school personnel are working together to provide the most appropriate program for the handicapped child.

It is imperative therefore that counselors follow procedures outlined by the law. The general and specific guidelines follow:

Multi-Disciplinary Assessment

Flow Chart--General

Child identified as possibly handicapped by

- school
- parents

Child is referred to appropriate school person

- counselor
- Pupil Personnel Dept.

Notice of Evaluation and Consent sent to parents

- child referred for evaluation
- why referred
- parents review all relevant school records
- procedures, types of tests and approximate dates
- parents right to meet with school psychologist
- right to object and request a hearing

Permission given to evaluate

- Permission not given
- Due process hearing
- Case is assigned to school district designee

Evaluation conducted

Psychological

Educational

Additional tests as indicated

(1) speech/language

(2) medical/psychiatric/neurological

(3) PT/OT

(4) hearing/vision

(5) referral to Base Service Unit for Home Evaluation Report as North Central Mobile Mental Health Staff

Results of Evaluation reviewed and interpreted by appropriate team

psychologist or counselor

teacher

supervisor/admtr. of Special Education or educational diagnostician

school nurse

others knowledgeable as North Central Mobile Mental Health Unit

If child is not handicapped, parents notified in writing

If handicapped, parents notified that:

child identified as handicapped

child is recommended for special education programs and services

will arrange an I.E.P. conference

I.E.P. Conference attended by

- school supervisor
- teacher
- the child, if appropriate
- parent(s)
- any other person the parent wants to attend
- any person the school wants to attend

Due Process Notice

- Approval, or
- Conference
- Hearing
- Appeal

Review/Revision and Re-evaluation

Multidisciplinary Assessment

Flow Chart--Specific

HANDICAP DETECTED

- Parent
- School Personnel
- Agency/Organization
- Child Find Project
- Physician or other Professional

PARENTS/CHILD REFERRED TO RESPONSIBLE SCHOOL PERSON

• In School:	Through Administrator to Counselor
• Out-of-School:	District Superintendent's Administrative Assistant or Special Education Supervisor

Family directed to enroll child in appropriate community school where evaluation process is initiated; family should make appointment to see administrator who will refer them to the counselor

INFORMATIONAL CONFERENCE/INTERVIEW WITH PARENTS OR SURROGATE

- Principal invites parents to school for interview.
- Principal requests counselor to work with parents and pupil for the purpose of discussing the possibility of a handicap, explaining the evaluation process and informing the parents of their rights pertinent to the intended evaluation.

PARENT ATTENDS CONFERENCE

Request for permission to evaluate explained:

- Informed of the intended evaluation;
- Informed why;
- Right to examine records explained;
- Informed of procedures, types of tests and dates;
- Informed of right to meet psychologist or other evaluators;
- Right to object;
- Right to consent.

PARENT SIGNS CONSENT FORM:

- YES: Evaluation Process Proceeds
- NO: School Cancels Plan to Evaluate OR Requests Due Process Hearing

PARENT DOES NOT ATTEND CONFERENCE

Request for permission to evaluate, written in native language of parent, is mailed.

School principal requests counselor, social worker or home and school visitor to make home visit (with parents' permission) to discuss the possibility of a handicap, explain the evaluation process and inform the parents of their rights pertinent to the intended evaluation.

PARENT SIGNS CONSENT FORM:

- YES: Evaluation Process Proceeds--counselor takes formal referral, case history and other relevant information.
- NO: School Cancels Plan to Evaluate OR Requests Due Process Hearing.

FORMAL EVALUATION INFORMATION OBTAINED

- School counselor begins child study evaluation team process. Arranges for opening file on particular child and the collection of data.
  - Nature of Referral Information:
    - Child/Parent Identifying Information;
    - Location;
    - Brief Description of Problem From Parental Perspective;
    - Identification of Parents' Goals and Potential Problems Needing Resolution;
    - Case History Questionnaire
    - Identify Sources of Existing Evaluative Information:
      - Family physician's report
      - Outside psychological report
      - Records from previous schools
      - Clinic reports
      - Agency reports as North Central Mobile Mental Health Agency
- Obtain release/consent forms of evaluative information for school use in assessment and planning.

SCHOOL-BASED CHILD STUDY EVALUATION TEAM OPERATING PROCEDURES

Counselor informs the school-based team of the particular child being evaluated and requests each team member to:

- Review Referral Information and Existing Agency, Clinic, etc., Reports in the Child's File.

- Perform Needed Evaluations/Observations;
- Summarize Evaluation/Observation Data, Hypothesis, Educational Implications/Goals and Further Assessments Needed on Summary Form; and
- Return Their Evaluation Protocols and Written Reports to the Counselor by the Specified Time. The Counselor Discusses the Additional Data and Reports with the Principal. Appropriate Material is Then Added to the Child's File and Notation Made on the Summary Form.

CHILD-STUDY EVALUATION TEAM MEETING SCHEDULED TO REVIEW CASE

With all information complete, principal and counselor plan and schedule child study evaluation team meeting; develop plan for notifying team members, outside evaluators and parents.

Information presented, reviewed, discussed, interpreted and group decision made regarding eligibility/need for special education programs/services and recommendations placement/environment according to individualized education program (I.E.P.) requirements, and in compliance with placement in least restrictive environment.

Child-Study Evaluation Team Includes*

Principal, co-chairperson

Counselor, co-chairperson

School psychologist
Child Study Evaluation Team Aide
Educational Diagnostician

Child's teacher

Parent (optional)

Other School District Evaluators

Outside Evaluators, if appropriate

* Same persons who participated in the evaluation.

MEETING OUTCOME INTERPRETED TO APRENTS IF NOT IN ATTENDANCE AT STAFF MEETING

Counselor interprets the outcome of the child-study evaluation team meeting to parents and counsel them regarding the nature of the child's identified handicap, if any, and requests their participation in an I.E.P. conference, if the child is found to be eligible for special education programs or services.

If child is not handicapped, parents notified in writing of such. Counselor discusses the team's decision with the child and his parents, informing them of their right to meet with the team. Counselor works with child and parents and, refers them to appropriate non-special education services in the school and/or community, if indicated.

APPENDIX

EXCEPTIONALITIES

Requirements from State Standards for a Student to be Eligible for Placement in Special Education Program(s) or Service(s)

Exceptionality	Assignment to Program Based on Evaluation and IEP that indicate such a program is appropriate	Special Evaluation Necessary	Other Requirements
Brain Damage		Neurological	
Learning Disabilities	X	Evaluation must assess specific academic strengths and weaknesses Appropriate Intelligence test must indicate average or above average intellectual functioning	
Mentally Retarded	Degree of Retardation and level of social and academic functioning shall be factors in determining the individual program		
EMR	X	I.Q. lower than 80	
TMR	X	I.Q. lower than 55	
SPMR	X	I.Q. lower than 30	Physician's Evaluation
Severely Multihandicapped			Can be assigned to Approved Private School if student has two or more of the following conditions: Blind Deaf Brain Damage C.P. Muscular Dystrophy Emotionally Disturbed Severely Mentally Retarded: ...Adaptive Behavior

Exceptionality	Assignment to Program Based on Evaluation and IEP that indicate such a program is appropriate	Special Evaluation Necessary	Other Requirements
Severely Multihandicapped (Continued)			...Individual I.Q. Score of lower than 25 ...Physician's Report
Socially/Emotionally Disturbed	X	Board Certified or approved Psychiatrist's Report (psychiatric reevaluation every 2 years)	
Visually Impaired	X	Evaluation must include an examination by an eye specialist	Written Report RE: Nature and degree of visual impairment is required
Hearing Impaired	X	Audiologist and otologist reports required	
Speech and Language Impaired	Screening by speech clinician and IEP must indicate that such a program is appropriate	Where Appropriate: ...certified public school psychologist ...physician	
Mentally Gifted		I.Q. of 130 or above Below 130 when other educational criteria indicate gifted ability	
Talented		Identification by a team of educators and professionals competent in areas of: art music dance theatre photographic arts Eligible persons go to Governor's School of The Arts	

Identifying Emotionally Handicapped Children

The following behavioral characteristics may serve as useful guideposts in identifying children suffering from emotional disturbance and/or social maladjustment. They are by no means exhaustive, but rather suggestive of the kinds of behaviors to which teachers should be altered. These behaviors should be considered indicative of emotional difficulties when they are seen as existing: (1) to a marked extent; and (2) over a long period of time.

(1) An inability to learn which cannot be explained by intellectual, sensory, or health factors

This is perhaps the single most significant characteristic of emotionally handicapped children in school. Despite average or above average intelligence these children experience repeated failure in the learning process. Such nonlearning may be manifested as an inability to profit from experience as well as inability to master skill subjects. This nonlearner seldom escapes recognition. Achievement tests often confirm what the teacher has long suspected. Emotional conflicts and/or resistances are the primary causal factor.

(2) An inability to build or maintain satisfactory interpersonal relationships with peers and teachers.

It isn't getting along with others that is significant here. Satisfactory interpersonal relations refers to the ability to demonstrate sympathy and warmth toward others, the ability to stand alone when necessary, the ability to have close friends, the ability to be agressively constructive and the ability to enjoy working and playing with others as well as enjoying working and playing with oneself. In most instances, children are unable to build or maintain satisfactory interpersonal relationships and are most visible to peers and teachers. Examples of typical behaviors are:

- rarely plays with other children
- has no friends (is a loner)
- other children act as if he is taboo or tainted
- plays with objects rather than people
- does not initiate relationships with other people
- uses others to gain own ends, reward while depriving them of same chance
- complains about others' unfairness and/or

discrimination toward him
- alienates peers by teasing, arguing or being cruel
- rarely shares with others
- plays with younger children instead of peers
- fights, hits, bullies, bosses peers
- openly strikes back with angry behavior to teasing of other children
- displays physical aggression toward objects or persons
- rarely participates in group activities
- "negative" contribution to classroom discussion and activities

(3) Inappropriate types of behavior or feelings under normal conditions.

These behaviors or feelings can often be sensed by the teacher and peer groups. "He acts funny" another child may say. The teacher may find some children reacting disproportionately to a simple command such as "Please take your seat." What is appropriate or inappropriate is best judged over daily and long-term observation of children, experience working and interacting with appropriate behavior of large number of normal children, as well as utilizing professional training. Some typical identifying behaviors are as follows:

- performs destructive acts
- destroys objects by breaking, tearing, crushing, etc.
- disregards school rules and authority
- physically/verbally acts out when asked to perform an activity by an authority figure
- responds negatively, not at all, or does the opposite when asked to perform an activity
- does not make decisions: extreme reliance on adult guidance, support, reassurance
- blows up, becomes excited, loses self-control when he cannot do or get what he desires, encounters problems, when offered constructive, helpful criticism, etc.
- withdraws or becomes aggressive for long periods when scolded, criticized, teased
- over-reacts to the slightest provocation
- displays inappropriate affect, facial expressions
- utters nonsense syllables or babbles to himself
- repeats one idea, thought or activity over and over
- makes distrustful or suspicious remarks about actions of others toward him
- perfectionistic: meticulous about having everything exactly right

- exhibits temper tantrums
- apologizes repeatedly for himself and/or his behavior
- resists learning new skills

(4) A general, pervasive mood of unhappiness or depression

Children who are unhappy most of the time may demonstrate such feelings in expressive play, art work, written composition, or in discussion groups. They seldom smile and usually lack motivation or interest in their school work or social relationships and is generally exhibited in some of the following examples:

- refers to himself as dumb, stupid or incapable
- expresses concern about being lonely or unhappy
- weeps or cries without provocation
- has rapid mood shifts: depressed one moment, manic the next
- is listless or continually tired

(5) A tendency to develop physical symptoms, pains, or fears associated with personal or school problems.

This tendency is often noted by the school nurse and parent. Illness may be continually associated with school pressures or develop when a child's confidence in himself is under stress. In some cases, such illnesses or fears may not be apparent to the teacher or peers. However, there are many cases of children who become sick before or after tests or have headaches before recitations. Speech difficulties, which may be a symptom of emotional stress, are usually visible to the teacher and parent. These children may display symptoms of:

- eczema
- hay fever
- asthma
- migraines
- uncleanliness
- malnutrition
- fatigability (is listless and/or continually tired)
- sleep disturbances (complains of nightmares, bad dreams)
- school phobia (expresses concern about something terrible happening to him or parent
- enuresis or encopresis

- nervousness (ticks, muscle twitching, eye blinking, nail biting)
- seizures (frequently stares blankly into space and in unaware of his surroundings when doing so)

Areas Related to Counseling

Self-Care Functioning

Possible Factors to Consider in Selecting Observation and Evaluation Data

Daily Living Skills

- Feeding/Eating/Drinking
- Dressing/Undressing
- Toileting
- Grooming
- Shaving/Menstruation
- Oral/Nasal Hygiene
- Clothing Care
- Object manipulation
- Health/Sanitation

Safety

- Awareness of danger
- Awareness of help/Aid
- Walking
- Using vehicles

Mobility

- Independence/Need for Assistance
- Active/Passive Transfer
- Wheelchair use skills
- Need for Special Precautions in positioning/Handling
- Need for Adaptive Equipment
- Need for Prosthetic Devices

Possible Resources for Assessment Information and Program Planning Suggestions

- Parents
- PT/OT
- Teachers
- Counselor
- Social Worker
- Home and School Visitor
- Ed. Diagnostician

Environmental Functioning

Possible Factors to Consider in Selecting Observation and Evaluation Data

Forces in the child's environment, including home, community and school, both positive and negative which impact on the child's functioning; and the child's effectiveness in adapting to the enrironment.

Family/Home/Neighborhood Influences

- Parents' Goals for Child/ Expectations/Understanding/Relationship
- Cultural factors/Primary Language Used in Home
- Socio-economic factors/ Is family receiving public assistance/ Supplemental Social Security Income (SSI)
- Family's ability to accept and manage child's problems/Behavior
- Special Needs: Clothing/ Medical Equipment/Bed/ Agency Assistance
- Child/Family's use of leisure time/Child's typical day/Social contacts
- Other problems family may be facing/Other children/ Health problems

Physical Factors of Child's Environment

- Architectural barriers to mobility/Home/Community/ School

Possible Resources for Assessment Information and Program Planning Suggestions

Parents/Child
Counselor
Home & School Visitor
Social Worker
Teachers
Community Agencies

Child's opportunity for experience/Stimulation/Mobility/Exploration

Community Living Skills

Child's abilities to use transportation (public and other); use telephone; use post office; use community services; know community and surroundings

Social Emotional Functioning

Possible Factors to Consider in Selecting Observation and Evaluation Data

Personal-Social Behavior

- Awareness of self and environment
- Responsiveness to social environment
  - Ritualistic/Perseverative
  - Self-stimulating/Self Mutilation
- Crying/Whining/Screaming
- Self-Concept/Self-Esteem
- Knowledge and acceptance of strengths and weaknesses
- Ego development/Identification
- Values/Interests
- Sexual Identification
- Social acceptance

Emotional Adjustment/Maladjustment

- Self-acceptance/Need for approval
- Organization/Attention/Concentration/Distractibility
- Activity/Energy levels/Passivity/Impulsivity
- Flexibility/Rigidity
- Tolerance/Coping/Frustration/Hostility
- Withdrawn/Aggression/Anxiety/Depression
- Specific behavior management problems

Possible Resources for Assessment Information and Program Planning Suggestions

- Parents
- Counselor/Home & School Visitor
- Teachers
- School Psychologist
- Parents
- Social Worker
- Psychiatric Consultant
- Ed. Diagnostician
- Resource Room Teachers
- E. D. Prog. Itinerants
- B.S.U. Psychologist

Interactive Relationships/ Peer/Family/Adults

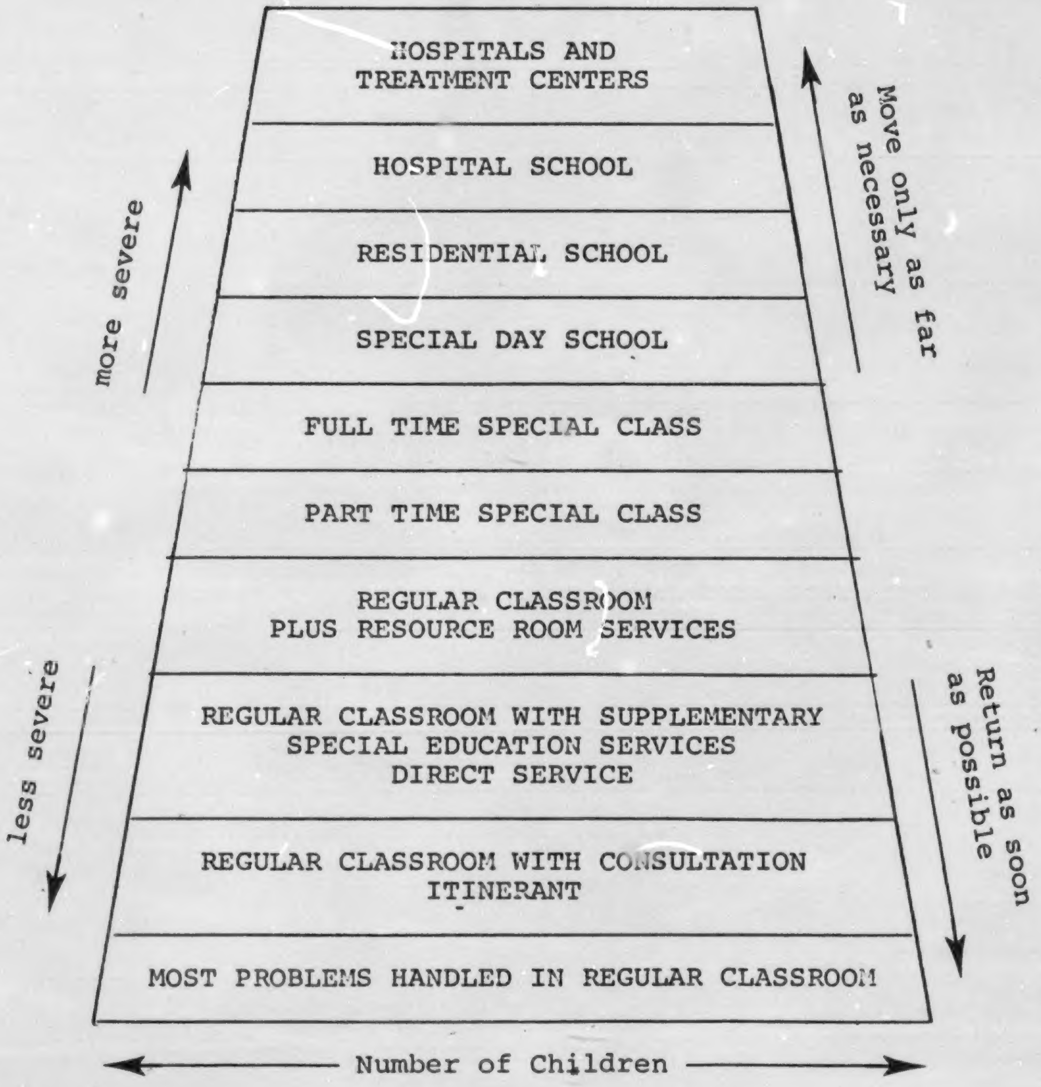
Dependence/Independence/
  Interdependence
Response to authority/Rules/
  Limits/Mores
Awareness of moral/Legal aspects
  of sexual activity
Awareness of environment
Sensitivity to needs and
  problems of others

Personality

Appearance/General attitude/
  Manner
Dependability/Predictability
Demeanor/Eye Contact
Cooperation

SPECIAL EDUCATION

A POINT OF VIEW


HOSPITALS AND TREATMENT CENTERS
HOSPITAL SCHOOL
RESIDENTIAL SCHOOL
SPECIAL DAY SCHOOL
FULL TIME SPECIAL CLASS
PART TIME SPECIAL CLASS
REGULAR CLASSROOM PLUS RESOURCE ROOM SERVICES
REGULAR CLASSROOM WITH SUPPLEMENTARY SPECIAL EDUCATION SERVICES DIRECT SERVICE
REGULAR CLASSROOM WITH CONSULTATION ITINERANT
MOST PROBLEMS HANDLED IN REGULAR CLASSROOM
more severe
less severe
Move only as far as necessary
Return as soon as possible
Number of Children

Relationships with Parents of Exceptional Children

What kind of a relationship should you have with the parents of an exceptional child from my class?

Relationships with parents of mainstreamed exceptional children should be no different from those you have with parents of the other children in your class. You may expect more enthusiasm and cooperation from the parents of the mainstreamed children than from the other parents. Parents of exceptional children want an honest evaluation of their child's problems and capabilities. The following recommendations regarding parent counseling should help you relate effectively to all parents. Part A consists of professional do's and don'ts regarding parental counseling. Part B consists of recommendations offered by parents regarding the relationship they desire with teachers.

Recommendations Regarding Parent Counseling

A. Professional recommendations to dilute, not dissolve, your problems:

1. DO:

    a) Report social as well as academic behavior.
    b) Keep written records of behavior incidents (preferably witnessed copies) and classroom worksheets.
    c) Report only observable behavior, i.e., behavior relevant to the school situation.
    d) Admit when you do not know why a child acts as he/she does.
    e) Encourage parents to have regular conferences, particularly regarding behavior problems.
    f) Be honest with yourself and with the parent.
    g) Go out of your way to involve both parents. Failure to do so may lead to:
        (1) Distortions of the situation
        (2) Marital friction
        (3) Disregard of your recommendations
        (4) Undue responsibility on one parent, particularly when a placement decision may be involved
        (5) Disassociation of uninvolved parent from consequences

h) Provide written feedback or follow-up of conference.

    (1) Give parents a document they or another professional can refer to at any time after the conference.
    (2) The written document reduces the chance a parent has of distorting and misunderstanding your concerns and recommendations.

i) Convey (at the end of your conference) that your interest is the beginning, not the end, of your involvement. Indicate that you will continue to:

    (1) Provide remedial assistance, and
    (2) Seek additional diagnostic and treatment assistance.

2. DON'T:

a) Diagnose, particularly behavior problems and suspicions of organic damage. Describe what you see; don't interpret it.
b) Interject your peculiar sensitivites and private personality theory into your portrayal of the child.
c) Keep secrets. A parent has a right to know that a child needs assistance. You are not deserting the child by sharing his/her problems in your classroom with parents. If you are concerned that a parent will punish the child, question yourself as to whether the child's needs are best met by selectively withholding information from his/her parents.
d) Use outdated, ambiguous, or unpleasant terminology.
e) Make long-term predictions.
f) Back down from a hostile parent when you know you are right. Rather,

    (1) Suggest talking to one parent at a time in this case.
    (2) Reschedule for another date, perhaps with the principal present.

g) Meet parents unprepared--be able to document your concerns.

B. Recommendations <ins>by parents</ins> to <ins>dilute, not dissolve</ins>, your mutual problems:

1. Do not ignore or overlook the fact that parents have certain problems to face: e.g.,
    a) Accepting the fact that their child may have a disability, defect, or imperfection. Partial or total nonacceptance of this fact creates emotional tensions in the parents.
    b) In cases where previous professional interventions have occured, parents may be reacting on the basis of inept, inaccurate, and ill-timed professional advice.
2. Give honest feedback as soon as possible.
3. Try to see both parents.
4. Use up-to-date terminology and down-to-earth language.
5. Recommend reading materials.
6. Show the parents how to teach things to their child.
7. Tell the parents what your behavioral and academic expectations are for their child.
8. Be willing to discuss the child's problem with the family doctor.
9. Know your resources.
10. Let the parents make their own decisions. Help them to see that it is their problem and their decision.
11. Help them to understand the problem.
12. Never put parents on the defensive.

District Resources

In addition to the Mental Health/Mental Retardation Agencies the following directories list sources of help to special education students in the Philadelphia area.

This is a listing of Service Directories, published by other Agencies in human services. The list is necessarily incomplete but represents the most recent compilation of Directories by the Division of Training, Information and Education, OMH/MR. These directories are available for perusal at offices of the Division, 10th floor, 1405 Locust Street, Philadelphia, Pa.

Whole city catalogues available at book stores.

RESOURCE DIRECTORY--MONTGOMERY COUNTY MH/MR, DRUG AND ALCOHOL PROGRAMS. A directory of catchment area resources, adult, children, pre-school, plus day programs interim care facilities, as well as supportive services for counseling, hot lines and women's programs; published--Montco PA, Feb. 76, 112 pages.

DIRECTORY OF LICENSED AND APPROVED LONG TERM CARE BEDS NURSING HOMES, IN GENERAL HOSPITALS AND REAHBILITATION FACILITIES. Prepared by Bureau of Licensure, Office of Quality Assurance and Certification, Dept. of Health (for all 5 county area), Dec., 1975, 117 pages.

GREATER PHILADELPHIA FEDERATION OF SETTLEMENTS DIRECTORY, 1971. A listing of participating Federation agencies at neighborhood centers throughout greater Philadelphia area. Published by Greater Philadelphia Federation of Settlements, 25 pages.

DIRECTORY OF GENERAL HOSPITALS PROVIDING WALK-IN MENTAL HEALTH EMERGENCY SERVICES. A national listing of all walk-in mental health service. DHEW publication #73-9022, 1973, 49 pages.

AGENCIES SERVING PEURTO RICAN COMMUNITIES. A resource listing of all Puerto Rican community services. Compiled by OMH/MR, 8 pages.

NORTH CENTRAL PHILADELPHIA COMMUNITY MH/MR CENTER TELEPHONE DIRECTORY. A directory of program services and 24 telephone listings, 1973, 14 pages.

DIRECTORY OF HALFWAY HOUSES FOR MENTALLY ILL AND ALCOHOLICS. State listings of halfway houses, DHEW publication #73-9008, 1973, 133 pages.

SOURCE BOOK OF PROGRAMS: 1976 STATE HOSPITALS. A directory of special clients services by geographic areas. American Institutes for Research, Palo Alto, CA, 216 pages.

COMMUNITY REFERRAL SERVICES MANUAL/PARC. A directory of all City programs for retarded citizens, Philadelphia Association for Retarded Citizens, Sept., 1976, 119 pages.

DIRECTORY OF ORGANIZATIONS INTERESTED IN THE HANDICAPPED. A national listing of all handicap assistance programs. Committee for the Handicapped/People to People Program, 1976, 48 pages.

BUREAU OF CHILDREN'S PREVENTIVE AND RESTORATIVE SERVICES DIRECTORY. A PA state listing of children's services. Commonwealth of PA, Dept. of Health, July, 1974.

EMERGENCY RESOURCES DIRECTORY. Listing of 5 county emergency services, compiled OMH/MR, 6 pages.

FAMILY SERVICE ASSOCIATION OF AMERICA DIRECTORY OF MEMBER AGENCIES. A national listing of all family resource programs, 1974, 93 pages.

AGENCIES AND INSTITUTIONS SERVING SOUTH PHILADELPHIA. A directory listing of organizations, addresses and phone numbers, published by Philadelphia area office, Health and Welfare Council, Inc., 13 pages, 1975-76.

DIRECTORY OF COMMUNITY ORGANIZATIONS IN SOUTH PHILADELPHIA. A listing of services and resources published by Philadelphia area office Health and Welfare Council, Inc., 8 pages, 1975-76.

DIRECTORY OF ETHNIC RESOURCES OF PHILADELPHIA IN DELAWARE VALLEY. A listing of all five county area organization and services, published: Ethnic Heritage Affairs Institute, July, 1976, 151 pages.

IN SERVICE TO THE MENTALLY RETARDED. A listing of national organizations assisting mentally retarded citizens, published by the President's Commission on Mental Retardation, 1970, 28 pages.

DIRECTORY OF COMMUNITY SERVICES OF THE GREATER PHILADELPHIA AREA. A comprehensive listing of all agencies, services by geographic area, published by Health and Welfare Council, Inc., 1976-77, 460 pages.

A GUIDE TO DRUG ABUSE RESOURCES: CODAAP, CITY OF PHILADELPHIA. A listing of all Philadelphia area services available in drug, alcohol programs; prepared by CODAAP, 131 pages.

RESOURCE DIRECTORY--COMHAR, INC. A Philadelphia area listing of all service organizations and facilities, especially useful to service proficers; prepared by COMHAR, Inc., 324 pages, 1977.

A DIRECTORY OF SERVICES FOR THE ABUSED CHILD AND THE ABUSIVE FAMILY/CARETAKER FOR PHILADELPHIA. Listing of all present and potential resources in Philadelphia, Health and Welfare Council, Inc., April, 1976, 38 pages.

SOUTHEASTERN REGIONAL DIRECTORY OF EARLY INTERVENTION SERVICES FOR YOUNG HANDICAPPED CHILDREN. A listing of services in SE PA, a Commonwealth of PA publication, 1975, 110 pages.

CHANNEL 12's SERVICE DIRECTORY FOR OLDER AMERICANS IN THE DELAWARE VALLEY. A listing of all services available to aged citizens, WHYY-TV, May, 1975, 12 pages.

1977 DIRECTORY SCHOOL DISTRICT OF PHILADELPHIA. A listing of all school district facilities, personnel, special services, Office of Informational Services, School District of Philadelphia, 1977, 86 pages.

PAAC'S HEAD START PAMPHLET OF SERVICES. A listing of all Headstart Programs in Philadelphia; also for handicapped. PAAC, 1977, 1 page.

DOMESTIC ABUSE: FACTS, WHERE TO GO, WHAT TO DO. A pamphlet listing of all tri-state area agencies in service to women, KYW-TV, 1977, 14 pages.

DIRECTORY OF NORTHEAST SOCIAL SERVICES. A listing of all social service agencies in NE Philadelphia. NE Community MH/MR Center of Friends Hospital, 1976, 21 pages.

KENSINGTON YOUTH SERVICES DIRECTORY AGENCIES AND COMMUNITY GROUPS. A listing of all children and youth services and late programs. Prepared by The Lighthouse, pages, April, 1977.

DIRECTORY: FEDERALLY FUNDED COMMUNITY MENTAL HEALTH CENTERS. A statewide listing of all federally funded mental health centers, National Institute of Mental Health, 1975, 42 pages.

A LISTING OF STATE AND TERRITORIAL MENTAL HEALTH, ALCOHOL, AND DRUG ABUSE AUTHORITIES AND PROGRAM CONTACTS. Alcohol, Drug Abuse, and Mental Health Administration, November, 1976, 56 pages.

U.S. FACILITIES AND PROGRAMS FOR CHILDREN WITH SEVERE MENTAL ILLNESS--A DIRECTORY. Compiled by the National Society for Autistic Children for the National Institute of Mental Health, 1974, 448 pages.

ORGANIZATION OF STATE SERVICES FOR THE MENTALLY RETARDED. A source book. Dec. 1973, 242 pages.

PENNSYLVANIA PROGRAM FOR WOMEN AND GIRL OFFENDERS, INC. A quick reference guide to neighborhood resources for women in Philadelphia, 1976, 86 pages.

RESOURCES FOR CHILDREN AND FAMILIES IN SOUTH PHILADELPHIA. Prepared by Jefferson Community MH/MR Center, Early Childhood Service-Linkage Program, 85 pages.

BASE SERVICE UNITS/COUNTY MENTAL HEALTH AND MENTAL RETARDATION PROGRAM--STATE. A listing of all addresses and telephone numbers.

COMMUNITY MENTAL HEALTH/MENTAL RETARDATION CENTERS AND BASE SERVICE UNITS--PHILADELPHIA. A listing of all address and telephone numbers.

COMMUNITY LIVING ARRANGEMENTS PROGRAMS--SE REGION. A complete listing of CLA Programs and facilities in five county area, 1975, 60 pages.

COMMUNITY RESOURCES AND SERVICES DIRECTORY FOR FAMILY CARE CARETAKERS. A listing of vocational educational sources and programs; 7 pages.

STATE SCHOOLS AND HOSPITALS IN PA. A total listing of all facilities and superintendents. Aug. 1975, 1 page.

Film Resource Sheet

REGIONAL RESOURCES CENTER/PRISE

1013 West Ninth Avenue
King of Prussia, Pennsylvania 19406
215/265-7321

LEAST RESTRICTIVE ENVIRONMENT/REGULAR CLASS PLACEMENT FILMS

DUE PROCESS HEARING
3/4" videotape/40 minutes/b&w/Pennsylvania Department of Education
RRC CODE: 6 PENDEO 01

Produced in cooperation with CEC, this tape portrays a due process hearing to help educators gain an understanding of the procedures involved in such sessions.

INCLUDING ME
40 minutes/color/1977/Capital Cities Television
RRC CODE: 6 CAPCIT 02

Designed to acquaint a general audience with P.L. 94-142, this film portrays a number of handicapped children and adults, and discusses their lives.

LIKE YOU, LIKE ME (SERIES)
10 films/6 minutes/color/1977/Encyclopedia Brittanica
RRC CODE: 3-ENCBRE-19a-j-01

LIKE YOU, LIKE ME is a series of ten, animated six minute films which use a story-line format to dramatize one or more handicapping conditions. These films are designed to help teachers and others with the problems of integrating handicapped children into the normal classroom setting.

LET'S BE FRIENDS (LIKE YOU, LIKE ME SERIES)
6 minutes/color/1977/Encyclopedia Brittanica RRC CODE: 3-ENCBRE-19a-01

This film, the first of ten, deals with Margaret, who is emotionally disturbed. When her teacher temporarily leaves the room in charge of Shelly, who is deaf, Margaret reacts rudely. Despite hurt feelings, Shelly and her friend Jill help Margaret in a way that only they can--with their friendship.

SEE WHAT I FEEL (LIKE YOU, LIKE ME SERIES)
6 minutes/color/1977/Encyclopedia Brittanica
RRC CODE: 3-ENCBRE-19b-01

Laura, who is blind, describes to her friend Jill a trip she took to the zoo with her parents. In her own special way--through her senses of smell and touch, and the sounds she heard, Laura tells of the goings-on at the zoo.

REGIONAL RESOURCES CENTER/PRISE
1013 West Ninth Avenue
King of Prussia, Pennsylvania 19406
215/265-7321

LEAST RESTRICTIVE ENVIRONMENT/REGULAR CLASS PLACEMENT FILMS

WHEN I GROW UP (LIKE YOU, LIKE ME SERIES)
6 minutes/color/1977/Encyclopedia Brittanica
RRC CODE: 3-ENCBRE-19c-01

Sidney and Shelly invite their friends to a costume party where they are to dress as the grownups they would most like to be. Laura, who is blind, wants to be a telephone operator; Steve, who has a prosthetic hand, comes as a farmer; and Tommy, who walks with braces, solicits votes as the town's future mayor.

EVERYONE NEEDS SOME HELP (LIKE YOU, LIKE ME SERIES)
6 minutes/color/1977/Encyclopedia Brittanica
RRC CODE: 3-ENCBRE-19d-01

The kids decide to hold a swap meet--a fair where they can trade their homemade items. Shelly, who is deaf, makes Play Doh sculptures; Jill plans to make necklaces; but it's Manuel, a stutterer, who surprises them all by singing: "If you do your best, you'll feel good about you."

LET ME TRY (LIKE YOU, LIKE ME SERIES)
6 minutes/color/1977/Encyclopedia Brittanica
RRC CODE: 3-ENCBRE-19e-01

In building a tree house in Martin's backyard, Billy has brought along his mentally retarded sister, Wendy, to help. When the children go inside to have a snack, Martin's overly protective grandmother insists it's unsafe for Wendy to play outside with the others. After a talk with Wendy's parents, she realizes that being with the other kids helps Wendy learn.

WHY ME? (LIKE YOU, LIKE ME SERIES)
6 minutes/color/1977/Encyclopedia Brittanica
RRC CODE: 3-ENCBRE-19f-01

Tommie, who needs double braces, finds out he will have to give up his trip to summer camp to go into the hospital for an operation. Feeling bitter, he enters the hospital where he meets a new friend, Ralphie. Ralphie envies Tommy's special talent--his ability to swim and the two meet weeks later so that Tommy can teach his new friend how to swim.

This handbook will hopefully serve as a resource until a more comprehensive guide is provided to you by the Division of Special Education.

Telephone, PO 5-4455- 4466 - 4488

THE SCHOOL DISTRICT OF PHILADELPHIA
BOARD OF EDUCATION
OFFICE OF DISTRICT FOUR
Leslie P. Hill School
THIRTY-SECOND STREET AND RIDGE AVENUE
Philadelphia, Pa. 19132

MICHAEL P. MARCASE
Superintendent of Schools

JEANETTE W. BREWER
District Superintendent

October 7, 1973

Mr. Norman Pitt
North Central Phila. CMH/MR Center
3701 N. Broad Street
Philadelphia, Pa. 19140

Dear Mr. Pitt:

This is to confirm our agreement for the following schools in District 4 to participate in the Mobile unit program.

Rhodes Middle School
Lehigh Elementary School
Strawberry Mansion Jr. High School
Gratz High School

Sincerely yours,

Israel Zeitlin
Administrative Assistant

IZ:er
cc: Mr. J. Hoffman
Mr. H. Rogers
Mr. E. Gillespie
Dr. D. Richardson
Mrs. A. Barksdale